DYSFUNCTIONAL ATTITUDES AND COPING MECHANISM AMONG SUB-STANCE DEPENDENT PATIENTS

A THESIS SUBMITTED TO

BABA FARID UNIVERSITY OF HEALTH SCIENCES, FARIDKOT (PUNJAB)

IN THE PARTIAL FULFILLMENT

FOR THE AWARD OF DEGREE OF

DOCTOR OF MEDICINE

IN

PSYCHIATRY

MAY 2023

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DEDICATED
TO
MY PARENTS,
MY PUNJAB
AND
MY PIND (CHAK 13Z,
SRI GANGANAGAR,RAJ)

ACKNOWLEGEMENT

I bow my head to the Almighty for the strength, endurance and perseverance throughout my project. I am deeply indebted to the Professor and Head of Department and my thesis co.guide Respected Dr.Ranjive Mahajan for his dedication and keen interest above all his overwhelming attitude to help his students. His timely advice, meticulous scrutiny, scholarly guidance and scientitic approach has helped me to accomplish this thesis.

My thesis guide Respected Professor Dr.Navkiran Sooch Mahajan for giving me the opportunity to do research and providing invaluable guidance throughout this research. Her dynamism, vision, sincerity and motivation have deeply inspired me. It was a great privilege and honor to work and study under her guidance. I am extremely grateful for what she has offered me. I would also like to thank her for her empathy, and great sense of humor. Thank you so much for facilitating me with your wisdom.

Their unfailing encouragement and their unwavering support and belief in me and for her exemplary guidance and genuine enthusiasm towards my thesis, understand and correct me whenever and whatever needed. It has been a privilege and honour to work under their guidance.

I am deeply grateful and would like to express my sincere gratitude to Professor Dr.Rupesh Chaudhry for his exemplary support. I also want to thank Dr. Pankaj Kumar, Assistant Professor and his inspiration throughout, along with Dr.Mitthat Miglani, Associate Professor, for all their support, valuable suggestions, motivation and supervision during my thesis work.

I am grateful to my mother Adv Mrs. Miankjeet Kaur Sandhu who always made my dreams and ambitions come true fighting against all the odds, father Sardar Amarpreet Singh Sandhu (Chak 13z, Sri Ganganagar, Raj) who made sure I always had a smile on my face, my brother Mr.Shabhadpreet Singh Sandhu, my massi Mr.Kiranjeet Sran and family and Mrs.Taranjit Sidhu and family for all their patience during my thesis time along with their encouragement and support all through my studies.

I would also like to thank my close friend and psychiatrist Dr.Mantaz Kaur Dhillon and family for helping me throughout my thesis, guiding me and supporting me.

This thesis has been kept on track and been seen through to completion with the support and encouragement of Senior residents Dr.Arun Kumar and Dr. Sunil Kochar and Dr.Jasleen Kaur Bhalla, Dr.Ruchika, Dr.Pretty Duggar my senior and numerous people including my co-PGs Dr.Aarti Gupta, Dr. Cherry Sikka and my juniors Dr. Nitin Baldeep Singh Duggal, Dr. Sandeep Dhillon and Dr. Alisha Aluna, Dr.Shagufta, Dr.Kimi, Dr.Rakshanda along with my other seniors and juniors, teachers, nursing staff , family, well-wishers, and colleagues. I would not forget to mention my friends from D.M.C.H Dr.Guryodh Jagga Sidhu , Dr.Bhagwant Lubana , Dr. Harman Batra and Dr.Manjeet Goyal for their unfailing encouragement and inspiration throughout my turbulent times. I am grateful to them for accommodating me with great patience at all the times.

I also express my gratitude to all my childhood , schooling and local close friends Adv. Angad Chahal, Adv. Amitoj DalehPawar, Adv. Karaninder Singh Bajwa, Adv. Gobind Brar , Adv.Himmat Sidhu, Adv.Ishwar Toor, Adv.Alam Sandhu, Adv.Alam Gill, Adv.Dil Jawanda ,Adv.Dhruv Mittal, Adv.Anmol Chandan, Adv. Chirag, Adv. Arvinder Gopi Kharaud, Adv.Harry Singh , Adv.Rajat Ghirra, Jhinder, Charat Singh, Balsher , Karman Toor, Umed Gill, ParamBawa, Harshit Mundi,

Mananjit Mundi , Dr.Armaan Sodhi, Dr.Rajvinder Singh , Dr.Harleen Bawa, Dr.Akshay Mahajan , Karsimran Kaur, Shubneet Kamra, Alisha Massey Himanshu Gaba, Shooter Anhad Jawanda , Geet Manjit Uniwala, Dr.Neetu Ahir, Dr.Jagmeet Singh, Dr.Raghav Gaur.

I also want to all Thank my parent college from where I did M.B.B.S my Batchelors Degree M.M.I.M.S.R (Ambala,Haryana) and my friends and colleagues there Dr.Kanwar Hira Bhangu, Dr.Yuvraj Bhandari, Major Dr.Birsukhman Singh Sian , Dr.Rajdeep Singh, Dr.Rajdeep Bajwa, Dr.Shehbaz Sidhu, Capt Dr.Purangad Khangura, Dr.Ravi Grewal, Dr.Jerry Sidhu, Dr.Gagan Sandhu, Dr.D.P Singh Mahal, Dr.Tejasvi Singh , Dr.Simarpreet, Dr.Amar Bains, Dr.Tanveer Dosanjh, Dr.Aryan, Dr.Lakesh, Dr.Gurwinder Bal, Dr.Inderjeet Sandhu , Dr.Saurab Bhandari, Dr.Anmol Mann, Dr.Yudhveer Sandhu, Dr.Mankiran Rai, Dr.JaskaranJassar, Dr.Gurinder, Dr.Angad Gill, Dr.Tanuj Chandok, Dr.Arjun Bhullar, Dr.Rishab Arora , Dr.Ajay Sran, Dr.Navdeep Bhangu , Dr.Gurmukh Dhaliwal, Dr.Gursimran Kalsi , Dr.Anubhuti Ralhan , Dr.Amanat Bajaj, Dr.Hargun Aulakh, Dr.Disha Soni , Dr.Shivangi Gautam, Dr.Tanvir Kaur, Dr.Ramita Chaudhary, Dr.Aman Saini

I would also specially Thank people from my native village Chak13z Sri Ganganagar,Raj Mr.Surinder Mitthu Dhillon and family and Mr.Parkash Kataria and family for always being there when needed.

At the end of my thesis, I would like to thank all those people who made this thesis possible and an unforgettable experience for me.
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Dr. Ardaas Preet Singh Sandhu

ABSTRACT

Background: Stress and dysfunctional thoughts are important determinants that lead individuals to start using substances or make them dependent to substances. There is a relationship between dysfunctional thinking patterns and coping attitudes such as avoidance and an inability to solve problems which leads to worsening substance-abuse issues and more relapses.

Aim: To assess dysfunctional beliefs and coping methods used by substance dependent patients.

Materials and methods: The study comprised of 100 consenting patients between 18-65 years, diagnosed with substance dependence as per ICD-10 for at least 1 year, of either gender, attending inpatient and outpatient psychiatry services of a tertiary care hospital. The data were collected by using the Socio demographic Pro-forma, the Dysfunctional Attitude Scale-40 items (DAS), and the Brief-Coping Assessment Questionnaire-28 items (Brief-COPE). The data was collected from April 2022 to January 2023.

Results: The minimum total DAS score among study subjects was 86 and maximum was 190 and the mean value was135.74±31.00.38% had high DAS score and12% subjects had very high DAS score, whereas 33% had low DAS score and 17% had Medium DAS score. Amongst the Sub Scales of the DAS scale in Perfectionist attitude value range the mean value was 66.20±18.83, Need for approval mean value was 33.01±8.12, Independent attitude value the mean value was 25.49±8.84 and varied attitude the mean value was 11.01±1.74.On Brief COPE, Problem Focused Coping score was 59.06±9.89, Emotion Focused Coping was 58.96±10.77, Dysfunctional coping was 54.25±8.62. The average COPE score of the patients diagnosed with drug addiction was found to be172.77±21.45. There was also a statistically significant positive relationship between DAS total scale and the emotion-focused coping subscale of COPE.

Conclusion: It can be concluded that these patients have Dysfunctional Beliefs and exhibit Avoidant coping attitudes. Assessment of such beliefs, attitudes and coping would help understand the, dependence and relapses in cases of substance dependence.

Keywords: dysfunctional belief, coping methods, substance dependence.

LIST OF ABBREVIATIONS

- ACTH-adrenocorticotropic hormone
- ADSI-Accidental Death & Suicides in India
- ASAM-American Society of Addiction Medicine ():
- C.O.P.D-chronic obstructive pulmonary disease
- COPE-Coping Orientation to Problems Experienced
- CPQ-Communication Patterns Questionnaire
- CRF-corticotropin-releasing factor.
- CS-coping strategies
- CSI-Coping Strategies Inventory
- DA-dysfunctional attitudes
- DAS-Dysfunctional Attitude Scale]
- DASS-Depression Anxiety Stress Scale
- DSM IV TR- Diagnostic and statistical manual
- HRSD-Hamilton Rating Scale for Depression
- HAM-A-Hamilton anxiety rating scale
- HAIS-Hanil Alcohol Insight Scale
- ICD-International Classification of disease
- IDUs-injecting drug users
- LEE - level of expressed emotion
- MADR-Montgomery-Asberg depression rating scale
- MDD-major depressive disorder.
- MOCS-mechanisms of coping scale
- NCRB-National Crime Records Bureau's
- PTSD-Post traumatic stress disorder
- QoL-quality of life
- SA-substance addiction
- SAD Q- Severity of Alcohol Dependence Questionnaire
- SID-substance-induced depression
- SUD-substance use disorder

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INTRODUCTION

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. The use of psychoactive substances causes significant health and social problems for the people who use them, and also for others in their families and communities. Substances of abuse include alcohol, opiates, cocaine, amphetamines, hallucinogens, prescription and over-the-counter drug abuse. Substance dependence (or Substance Addiction) can be defined as a chronically relapsing disorder characterized by compulsion to seek and take the drug, loss of control in limiting intake and emergence of a negative emotional state (e.g., dysphoria, anxiety, irritability) when access to the drug is prevented. [1-3] Moreover, the current medical consensus is that the key feature of substance addiction is compulsive drug use despite significant negative consequences. [4,5]

Addiction is defined as the frequent and excessive use of substance and the inability to stop the desire to take substance in such a way as to disrupt the individual's physical and mental health, family, social and work harmony. [6-8] Addiction- according to the American Society of Addiction Medicine (ASAM): "Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward or relief by substance use and other behaviors." Addiction is now termed "use disorder," and is characterized by an inability to consistently abstain, craving the drug, impairment in behavioral control, diminished ability to recognize significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, use disorder often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, use

disorder is progressive and can result in disability or premature death." [9-13]

Drug addiction has many negative outcomes such as breakdowns in relationships with parents and the social lives of the people involved. According to estimations of the United Nations International Drug Control Program, there are 180 million drug addicts in the world. [14] It has been reported that the lifetime prevalence rate of substance abuse for those aged 18 and over is 16.7% in the United States. The substance abuse rates in males were found to be higher than females in the 15–24 years' age group. Many factors, such as rapid increase of the population; weakening of cultural and social ties; late marriage and child births, lack of education, and open and free use of the Internet, have increased the prevalence of substance abuse among the youth. Inappropriate Internet use by children and adolescents can especially cause them to establish identification with negative lifestyles and break with the traditional social and family life, perhaps facilitating the use of these substances. Social, psychological, biological, and familial factors may affect the etiology of substance abuse. [15]

A 2019 national study conducted by AIIMS-Delhi on the prevalence of drug abuse in the country, establishes that: A substantial percentage of people use psychoactive substances (alcohol, cannabis and opioids), and adult men top the list of drugs users. About 14.6% of people in the age group 10-75 year i.e., about 16 Crore people consume alcohol. The prevalence of alcohol consumption is 17 times higher among men than women. States with high prevalence (more than 10%) of alcohol use disorders are Tripura, Andhra Pradesh, Punjab, Chhattisgarh, and Arunachal Pradesh. About 2.8% of Indians (3.1 Crore individuals) reported of having used any cannabis product within past 12 months (Bhang – 2% or 2.2 crore people; Ganja/Charas – 1.2% or 1.3 Crore people). States with the higher than national prevalence of cannabis use are Uttar Pradesh, Punjab, Sikkim, Chhattisgarh and Delhi. Prevalence of current use of opioids overall is 2.06%. About 1.08% of

Indians in 10-75 year age group approximately 1.18 crore people are current users of sedatives (non-medical, non-prescription use). Uttar Pradesh, Maharashtra, Punjab, Andhra Pradesh and Gujarat are the top five states which house the largest populations of people using sedatives. Cocaine (0.10%), Amphetamine Type Stimulants (0.18%) and Hallucinogens (0.12%) are the categories with the lowest prevalence of current use in India. Alcohol is the most commonly abused psychoactive substance followed by cannabis, opioids (heroin, opium) and inhalers. Addiction generally begins with alcohol, moves towards nicotine and cannabis – considered as gateways to hard drugs – and then hard substances. [16]

According to National Crime Records Bureau's (NCRB) annual Accidental Death & Suicides in India (ADSI) reports: In the year 2021, all India rate of suicides (i.e. the number of suicides per one lakh population) was 12.0. Andaman & Nicobar Islands reported the highest rate of suicide (39.7) and in Punjab it was 8.1. Drug Abuse/ Alcoholic Addiction was reported as cause of suicide in 6.4% cases. Even in the data relating to deaths due to road accidents, drugs & alcohol are one of the most causative factors. [17]

A wide range of psychological, social, domestic, and biological factors are involved in the etiology of substance abuse, none of which can be a determinant factor on its own. [18] The dysfunctional attitudes, which are one of the psychological factors, have an important role in the onset of drug use and addiction. [18,19] Dysfunctional attitudes are biased assumptions and beliefs that the subject has toward himself and his surrounding and future world. [19] In other words, dysfunctional attitudes (DA) are attitudes and beliefs that predispose the individual toward depression or psychological disorders, as a whole. These beliefs are based on past experiences gained by the person about himself and his surrounding world, and lead him to interpret specific situations in an exaggeratingly negative way. In Beck's opinion, DA are inflexible and idealistic criteria the individual uses to judge himself and

others. Since these attitudes are inflexible, extremist and resistant toward change they are considered dysfunctional or futile. [20] According to available literature, addiction procedures are influenced by the patients' beliefs and attitudes. [21] Beck has underscored the role of dysfunctional and maladaptive attitudes and cognitions in creating maladaptive behaviours. In his opinion, clients must first become aware of what goes on in their minds. Afterwards, they must identify their incorrect thoughts and begin to replace them with correct ones. By receiving the necessary feedback they will realize the correctness of their judgments and complete their course of treatment. The roles of other beliefs, attitudes and mental processes have been proven in many other behavioural disorders and problems and have shown that irrational beliefs can aggravate a person's suffering. [22] Dysfunctional attitudes are reportedly associated with maladaptive coping strategies. There is a relationship between dysfunctional thinking patterns and coping attitudes such as avoidance and an inability to solve problems. Dysfunctional attitudes are related to every aspect of one's life who is under addiction. Religion/culture is one example of an emotional coping strategy, for instance in Sikhism the use of any tobacco product or smoke via drug use from a sardars nose/mouth are thought to be very inappropriate due to social and religious stigma compared to other religions so they tend to consume more alcohol. Sotoodeh et al compared Dysfunctional Attitudes and thought control in amphetamine-dependent and healthy people in Tehran, and found significant differences between the two among the two groups. [23]

The process associated with dysfunctional attitudes, beliefs, and psychological disorders is often associated with the stress-coping mechanisms of an individual. If the perspective of an individual to the outside world has a solid and perfectionist structure, coping strategies that are not adaptive, such as denial or avoidance, are observed in stressful situations. Stress is an important factor leading individuals to the use of drugs. Coping involves efforts to manage and control environmental demands and has two important applications: regulating

unpleasant emotions and reacting in such a way that can alleviate the problem causing distress. [24-26] Researchers believe that people prefer to use specific coping strategies in stressful situations, which in fact shape the individual's coping style. [27] Earlier studies suggest that individuals either learn how to live with stressful situations or cope with them. Lazarus and Folkman identified three types of coping strategies (CS), namely problem focused, emotion focused, and avoidance. Problem-focused coping is often adaptation oriented. [24,28] The problem-focused coping method has been determined to be underused by drug-addicted people. Several studies have suggested that substance-use behaviour is associated with coping methods that are not directed toward adaptation. Adaptive stress coping leads to improvement and better adaptation, according to stress-coping research. [29]

Research findings show that addiction is related to the way people cope with stress, [30] such that the dimensions of CS are noteworthy in foreseeing substance abuse, the frequency of abuse, completing the treatment course and relapse in addicts. [31] Moreover, associations have been reported to exist between weak CS and inappropriate problem-focused methods and substance abuse in addicts. [32,33] Other studies too have observed the association between CS and reduction of psychological distress. [34] Therefore, in addition to creating different emotional reactions such as anger, anxiety and depression, stressful events can predispose individuals to turn to negative health behaviours such as alcohol abuse, smoking etc. [35]

Relapse needs to be viewed as a process – as a series of maladaptive responses that eventually lead to the act of taking drugs. [36] A relapse is when a person after a period of sobriety, makes a full-blown return to drinking and/or using drugs, while a lapse is a brief "slip" where a person may drink or use, but then immediately stop again. [37] A host of clinical and survey studies indicate that drug abusers and alcoholics often cite stress and negative affect as reasons for relapse to drug use.

[38,39] Furthermore, psychological research has long supported the need to address stress coping in empirically validated behavioral treatments of addiction. [40,41] However, despite the efficacy of several behavioral interventions in addiction treatment, [42] it is well known that relapse rates in addiction remain high and the chronic relapsing nature of addiction needs specific attention in addiction treatments. [38,43,44] There is now growing recognition from the preclinical and human neuroscience research that dysregulation in brain stress and reward pathways may play a key role in addiction relapse. [38,45]

There also is evidence of stress system involvement in relapse outcomes in alcoholics and smokers. Negative mood and stress-induced alcohol craving and blunted stress- and cue-induced cortisol responses have been associated with alcohol relapse outcomes. [46-49] Nicotine-deprived smokers who were exposed to a series of stressors showed blunted ACTH, cortisol, and blood pressure responses to stress but increased nicotine withdrawal and craving scores. These responses were predictive of nicotine relapse outcomes. [50] Thus, for alcoholic and smoking samples, as in the cocaine group, it appears that the drug-craving state marked by increasing distress and compulsive motivation for drug (craving), along with poor stress regulatory responses (altered glucocorticoid feedback or increased noradrenergic arousal) results in an enhanced susceptibility to addiction relapse (Figure 1).

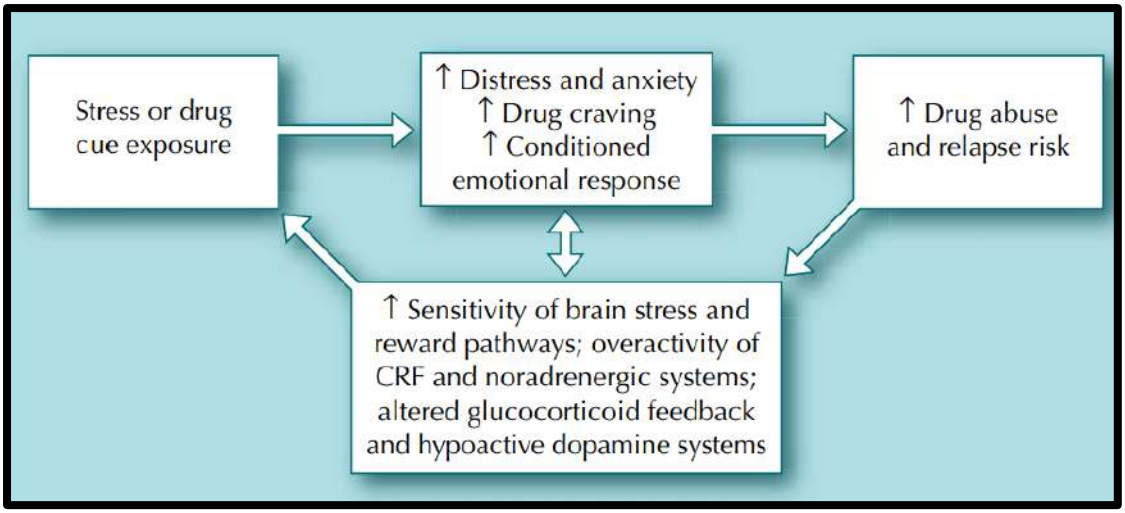
Stress or drug cue exposure
↑ Distress and anxiety
↑ Drug craving
↑ Conditioned emotional response
↑ Drug abuse and relapse risk
↑ Sensitivity of brain stress and reward pathways; overactivity of CRF and noradrenergic systems; altered glucocorticoid feedback and hypoactive dopamine systems

Figure 1: A schematic model of stress-related mechanisms that increase relapse susceptibility. CRF—corticotropin-releasing factor.

Stress responses and stress-related coping are complex phenomena that are affected by multiple developmental, genetic, and individual factors. For example, early trauma and child maltreatment alter stress responses and affect addiction vulnerability. [51,52] Genetic factors are important in emotion processing and in response to stressful life events [53,54] and may be important in stress-related relapse susceptibility in addictions. Psychiatric comorbidity and individual differences in coping ability, executive function, and impulse control can influence stress coping and addiction vulnerability as well. [55]

There was a need to examine these in this region of the country because problem of use has been on the rise for the previous 10 to 12 years. In the context of dysfunctional beliefs and coping mechanisms among substance abusers, there is a parity of Indian literature. In summation, substance abuse is a major mental health issue that many people experience and is linked to their dysfunctional attitudes and inadequate coping skills. Incorporating an appropriate psychological intervention with the pharmacological therapy of such patients in terms of recovery, relapse prevention, and rehabilitation will be made possible with the aid of assessment of these dysfunctional attitudes

and maladaptive coping mechanisms. Therefore, the current study was conducted to assess patients with drug use disorders' dysfunctional attitudes and coping mechanisms.

AIM AND OBJECTIVE

To assess the dysfunctional attitude and coping mechanism among substance dependent patients.

REVIEW OF LITERATURE

SUBSTANCE ABUSE

Substance or drug can be defined as anything that has the potential of causing addiction, habituation or altered consciousness. It can also be defined as any chemicals that can change the structure or function of the body. Drugs are used for nutritional or medical purposes following Doctors' prescription but become potentially hazardous when used for other purposes. [36] Substance abuse is the recurrent use of substance that may cause physical or social harm to the user or others but not associated with any symptoms when the substance is stopped. However, Substance addiction (or dependence) is defined as a compulsive pattern of substance use characterized by a loss of control over the use of the substance and continued use despite the significant substance-related problems and the emergence of a state of physiological need such that a physiological signs and symptoms, known as withdrawal symptoms, occur when access to the drug is prevented. [37] Generally, three things are usually associated with addiction: inability to stop, tendency of increasing dosage or behavior and withdrawal symptoms, those symptoms that develop following abstinence of drug. [38]

In India opioids are commonly used by injecting drug users (IDUs). These opioids include heroin ('smack' / 'brown sugar') as well as pharmaceutical opioids (such as buprenorphine, pentazocine and dextro-propoxyphene). In the north-eastern region, heroin and dextropropoxyphene are the most commonly used opioids; impure heroin (smack), and buprenorphine are the most commonly used opioids in metropolitan cities such as Delhi, Mumbai, Chennai and Kolkata. Pentazocine is the most commonly injected opioid in Karnataka, Andhra Pradesh, and Chhattisgarh. In the states of Punjab and Haryana, buprenorphine is commonly used by injectors. As per the HIV sentinel surveillance report, HIV prevalence among IDUs in India is

7.2%. However, some states have much higher HIV rates among IDUs such as HIV prevalence among IDUs is 21% in Punjab, 18% in Delhi and around 12% in Manipur and Mizoram. [39]

Implications of substance abuse

The implications of substance abuse to the life of an individual are enormous and can be categorized as Social, Physical, Medical or Psychiatric/Psychological.

Social implications: There are many social implications of substance abuse ranging from loss of employment, break up of interpersonal relationship, truancy and drop out from schools, suicidal ideation, road traffic accidents and unprotected sex. [40] Many researchers have demonstrated a significant relationship between abuse and unemployment which lead to serious mental problems in the addicts which was thought to be as a result of behavioral changes caused by pre-existing psychopathology. [41] Family disruption and decrease or absence of parenting capacity has been established in individuals with substance abuse that results into child abuse, child neglect and abandonment with significant and serious impairment of parent-child interaction. [42] A significant link between consumption of illicit drugs and increase crime rate among abusers has been shown to exist by many literatures which is more pronounced in alcohol abusers.

Physical implications: Physical abuse means all forms of maltreatment that may result into physical injuries like bruises, lacerations, fractures or burns. Neglect such as failure to provide food, shelter, clothing or medical concern to children can be considered as a form of physical abuse. Furthermore, sexually abusive behavior like raping, touching, kissing or even caressing may be considered as physical abuse. [43] Substance abuse was shown to be related with self-afflicted physical injuries like cutting, bruising or even burns. According to Blose et al, injury-related hospital admissions among addicts are by far higher than injury-related hospital admissions in non-addicts. [44]

Medical implications: About 47% of the patients have infectious complications with pulmonary infections as the most commonly identified infections largely due large percentage of heroin abusers accounting for about 95%. About 16.4% of the patients have viral hepatitis, 11.1% have human immunodeficiency virus infection, 9.3% have minor genital infections and about 2.6% have bone and joint infections and sepsis and endocarditis respectively. [45] In a case report of Goel et al, a prolong and sustained bacteremia was found in a 25-year old intravenous drug addict which persists with even multiple regimens of antibiotics which confirm a risk of bacteremia in intravenous drug addicts. [46] In a study by Possi, inhalants like Glues is strongly associated with risk of Lung, brain, and liver damage or even death through suffocation or choking, and anemia. Whereas Heroin abuse is correlated with risk of brain and liver destruction, drug induced hepatitis and embolism. [36]

Psychiatric/psychological implications: Wide ranges of clinical as well as epidemiological studies have demonstrated the link between substance abuse, particularly alcoholism and chronic anxiety disorder and was found to be more common in men than women. Also, elevated rates of anxiety disorder were found in relatives of patients with alcoholism in many family studies. These findings indicate that alcoholism contribute to the development of anxiety disorders. [44] In a study by Sareen et al, an association between anxiety disorders like social phobia, panic disorder, agoraphobia, specific phobia, and generalized anxiety disorder with chronic use of amphetamines, cocaine, hallucinogens and heroin were established in two American communities. [47] Many studies have shown the relationship between maternal addiction to cocaine, alcohol, or heroin during pregnancy and significant decrease in cerebral reserve capacity and functions and decrease brain size of the newborn with less ability to compensate for the loss of the brain function during adulthood which may progress to neurodegenerative diseases like Alzheimer's disease and presenile Dementia. [48]

COPING MECHANISM

Coping is defined as the thoughts and behaviors mobilized to manage internal and external stressful situations. [49] It is a term used distinctively for conscious and voluntary mobilization of acts, different from 'defense mechanisms' that are subconscious or unconscious adaptive responses, both of which aim to reduce or tolerate stress. [50]

When individuals are subjected to a stressor, the varying ways of dealing with it are termed 'coping styles,' which are a set of relatively stable traits that determine the individual's behavior in response to stress. These are consistent over time and across situations. [51] Generally, coping is divided into reactive coping (a reaction following the stressor) and proactive coping (aiming to neutralize future stressors). Proactive individuals excel in stable environments because they are more rigid, and are less reactive to stressors, while reactive individuals perform better in a more variable environment. [52]

Coping scales measure the type of coping mechanism a person exhibits. The most commonly used scales are COPE (Coping Orientation to Problems Experienced), Ways of Coping Questionnaire, Coping Strategies Questionnaire, and Coping Inventory for Stressful Situations, Religious-COPE, and Coping Response Inventory. [53]

Coping is generally categorized into four major categories which are: [49]

1. Problem-focused, which addresses the problem causing the distress: Examples of this style include active coping, planning, restraint coping, and suppression of competing activities.

2. Emotion-focused, which aims to reduce the negative emotions associated with the problem: Examples of this style include positive reframing, acceptance, turning to religion, and humor.

3. Meaning-focused, in which an individual uses cognitive strategies to derive and manage the meaning of the situation

4. Social coping (support-seeking) in which an individual reduces stress by seeking emotional or instrumental support from their community.

Many of the coping mechanisms prove useful in certain situations. Some studies suggest that a problem-focused approach can be the most beneficial; other studies have consistent data that some coping mechanisms are associated with worse outcomes. [49,54] Maladaptive coping refers to coping mechanisms that are associated with poor mental health outcomes and higher levels of psychopathology symptoms. These include disengagement, avoidance, and emotional suppression. [55]

The physiology behind different coping styles is related to the serotonergic and dopaminergic input of the medial prefrontal cortex and the nucleus accumbens. [52] The neuropeptides vasopressin and oxytocin also have an important implication relative to coping styles. On the other hand, neuroendocrinology involving the level of activity of the hypothalamic-pituitary-adrenocortical axis, corticosteroids, and plasma catecholamines were unlikely to have a direct causal relationship with an individual's coping style. [56]

Patients using maladaptive coping mechanisms are more likely to engage in health-risk behaviors than those with appropriate mechanisms. They are also more non-adherent and more likely to use cigarettes or alcohol. [57]

Coping influences patients' compliance to therapy and the course of the disease by lifestyle changes. In disorders where non-medicinal treatment plays a role in the progression, coping mechanisms are important in determining the severity of such conditions. Coping styles may be helpful in patients' educational programs or psychotherapy, and

paying attention to them could contribute to the prevention of sequelae. [58,59]

The importance of coping styles does not only affect the patients alone but also their physicians and nurses. Healthcare workers are more likely to choose a problem-oriented coping mechanism while the tendency to choose avoidance decreases with age and employment duration. The incidence of burnout syndrome decreases with the use of problem-oriented coping mechanisms, social integration, and the use of religion. [60,61]

Understanding coping mechanisms is a cornerstone in choosing the best approach to the patient to build an effective doctor-patient relationship. The need to monitor the patient's level of distress and coping mechanisms arise because patients who adopt maladaptive mechanisms are more likely to perceive their doctors as being disengaged and less supportive. This perception is clinically significant because about one out of four cancer patients use a maladaptive coping mechanism. [62]

The relation between maladaptive coping mechanisms and numerous disorders has been established. Psychiatric disorders such as PTSD, anxiety, and major depression, and somatic symptoms were all correlated with coping styles related to avoidance. [63] This scenario holds for other disorders such as hypertension and heart diseases, where maladaptive coping strategies were used by patients who had more severe symptoms. [64]

Understanding the coping styles is central to support the patient's coping efforts. Talking with the medical staff to seek information and social support was the most popular coping strategy in anxious surgical patients. Monitoring patients' coping strategies using various coping scales (e.g., COPE, Ways of Coping Questionnaire, Coping Strategies Questionnaire) can help in evaluating the patient's psychological status and continued improvement. [65]

BRIEF-COPE

The Brief-COPE is a 28 item self-report questionnaire designed to measure effective andineffective ways to cope with a stressful life event. “Coping” is defined broadly as an effortused to minimize distress associated with negative life experiences.

The scale is often used in health-care settings to ascertain how patients are responding to aserious diagnosis. It can be been used to measure how someone is coping with a wide rangeof adversity, including a cancer diagnosis, heart failure, injuries, assaults, natural disastersand financial stress.

The scale can determine someone’s primary coping styles as either Approach Coping, or Avoidant Coping. In addition, the following subscales are reported: Self-distraction, Active coping, Denial, Substance use, Use of emotional support, Use of instrumental support, Behavioral disengagement, Venting, Positive reframing, Planning, Humor, Acceptance, Religion, & Self-blame.

The Brief-Cope was developed as a short version of the original 60-item COPE scale, [66] which was theoretically derived based on various models of coping. The Brief Cope was initially validated on a 168 participant community sample whom had been impacted by a hurricane, [67] and shown to have adequate factor structure.

Subsequent factor-analysis [68] with heart failure patients indicated two major factors:

1. Avoidant Coping.

2. Approach Coping.

Scores are presented for the two overarching coping styles:

1. **Avoidant Coping**, which is characterised by the subscales of denial, substance use, venting, behavioural disengagement, self distraction

and self-blame. Avoidant Coping is associated with poorer physical health among those with medical conditions. Compared to Approach Coping, Avoidant Coping is shown to be a less effective at managing anxiety.

2. **Approach Coping** is characterised by the subscales of active coping, positive reframing, planning, acceptance, seeking emotional support, and seeking informational support. Approach Coping is associated with more helpful responses to adversity, including adaptive practical adjustment, better physical health outcomes and more stable emotional responding.

DYSFUNCTIONAL ATTITUDES

Dysfunctional attitudes are beliefs and attitudes that induce negative thoughts about the self, others, and the future. [18] Dysfunctional attitudes are biased assumptions and beliefs that the subject has toward himself and his surrounding and future world. In other words, dysfunctional attitudes (DA) are attitudes and beliefs that predispose the individual toward depression or psychological disorders, as a whole. [20] Dysfunctional attitudes are related to every aspect of ones life who is under addiction.

Dysfunctional Attitude Scale

The Dysfunctional Attitude Scale (DAS Forms A and B) [69] was employed to assess the level of dysfunctional attitudes. The DAS is most frequently employed in priming studies as a schema indicator. [70] Each form has 40-items and uses a 7 point Likert scale. DAS A and B have been reported to have high internal consistency, with .86 and .87 alphas coefficients respectively. [69]

Numerous researchers have conducted studies to assess patients with substance use disorders' dysfunctional attitudes and coping mechanisms, as follows:

Parker G et al., (1984) [71] assessed equivalent forms of Weissman's Dysfunctional Attitude Scale in 251 Australian patients routinely attending their general practitioner. Normative scores were strikingly similar to those reported in North America. The influences of demographic variables on scale scores were examined, and factor analyses suggested four key attributional constructs. In a second study of 43 clinically depressed patients we assessed the degree to which higher Dysfunctional Attitude scores might be an antecedent to, or a consequence of, greater depressive severity and found support favouring the latter explanation.

Calache J et al., (1994) [72] examined whether substance abusers have more maladaptive thinking patterns than controls. The Dysfunctional Attitude Scale (DAS) was administered to 38 substance abusers and 30 healthy age-matched controls. Nineteen substance abusers (50%) were depressed and 19 were non-depressed. Both depressed and non-depressed substance abusers had significantly higher DAS scores than controls. Depressed substance abusers had higher scores than non-depressed substance abusers. There was no correlation between age, sex, age of onset or the nature of the substance used and DAS scores in either group of patients. There was a trend for an elevation of DAS scores with chronicity of dependence among depressed substance abusers. The results support the hypothesis of the presence of maladaptive thinking patterns among substance abusers, and suggest a need for further exploration of their cognitive styles and of the use of cognitive therapy in the treatment of addiction.

Tofani H & Javanbakhat M (2001) [73] investigates coping patterns and dysfunctional attitudes among a group of clients at Mashhad Welfare Center as substance abusers comparing with those of control group. 50 male substance abusers were selected randomly and matched with control group with regard to age, education, job and income level. Dysfunctional Attitude Scale and Coping Skills Questionnaire were applied in this study. Results showed that during stressful period of life,

substance abusers had weaker problem-solving strategies, cognitive evaluation and social support compared with control group. This study showed that cognitive therapy and coping skills training could be beneficial for primary and secondary prevention.

Ramsey SE et al., (2004) [74] examined the accuracy with which the depressive episodes of alcoholics undergoing treatment are classified as substance-induced depression (SID) or independent major depressive disorder (MDD).Participants were 95 patients (64 men) undergoing partial hospital treatment for alcohol dependence. Affective disorders were assessed at baseline and 6 weeks, 3 months, 6 months and 12 months later. Over one quarter of the depressive episodes originally diagnosed as SID were reclassified as MDD during the 1-year follow-up, due to a continuation of the depressive episode despite a period of prolonged abstinence from alcohol and drugs. Both history of MDD and lower levels of alcohol dependence were associated with diagnostic change from SID to MDD. These findings support the diagnostic complexity of these two types of depressive disorders and point to clinical features that may differentiate them.

Floyd M et al., (2004) [75] examined the factor structure with a sample of 100 depressed older adults (average age = 68.19; average initial Hamilton Rating Scale for Depression [HRSD] score = 16.72) who participated in a depression treatment study. Results indicated the factor structure established with younger adults was not replicated with older adults. Furthermore, the factor structure with older adults was uncertain: a single factor structure, two-factor structure, and three-factor structure were essentially of equal validity. The uncertainty of the latent structure of the Dysfunctional Attitudes Scale Form A (DAS-A) suggests that it should be interpreted with caution whenever used with older adults.

Alizadeh KH et al., (2009) [76] assessed the role of dysfunctional attitudes, outcomes of psychology in substance abuse behaviors of subject who were referred to addiction treatment center in the city of

Bandar Abbas, and to compare the with the control group, in a retrospective study. Study included 100 subject substance abusers who were compared with 100 subject s of control group who were selected using convenience sampling and were also demographically matched. Data were gathered using a demographic questionnaire, clinical interview, dysfunctional attitudes scale (DAS), Depression Anxiety Stress Scale (DASS). Findings indicated that in comparison with control group, subject of substance abusers had experienced more stress, anxiety, depression, had shown a cognitively more percent of them dysfunctional attitudes in comparison with control group. The results suggested that the dysfunctional attitudes could be as a Vulnerability Factor that increase abuse of substance consequently use of cognitive therapy could be helpful and effective in prevention and treatment of the addicts.

Kërqeli A et al., (2013) [77] attempted an experimental design to examine changes in the dysfunctional attitudes in participants with and without depressive symptomatology following negative and positive mood induction and tested whether dysfunctional attitudes predicted symptoms of depression after one month. In the study took part one-hundred sixty undergraduate students in Kosovo. Results indicated that there was a slight decrease after negative mood priming in the level of dysfunctional attitudes for both groups of participants; however, after positive mood priming there was an increase for both groups. Nonetheless, hierarchical regression analysis results revealed that the model of prediction with the level of dysfunctional attitudes after both priming conditions and the group of depressive symptomatology explains a proportion of variance in depression 28.7% ($\Delta R2 = .24$, Fchange (3, 91) =10.655, $p < .001$). Findings suggest that negative mood priming is not a successful procedure in eliciting dysfunctional attitudes and that there is no difference based on depressive symptomatology in the increase of dysfunctional attitudes after mood priming. Further attention needs to be paid to the effects of positive mood priming. Nevertheless dysfunctional attitudes predict symptoms

of depression, thus supporting Beck‘s model but the level of dysfunctional attitudes assessed after positive mood priming predicted symptoms of depression in a negative linear direction pointing to differences in findings and questioning the universality of the cognitive model of depression across cultures.

A'zami Y et al., (2015) [78] conducted a causal-comparative study including 100 addicts attending Robat-Karim’s addiction rehabilitation centers who were selected through simple random sampling. Another 100 ordinary individuals were matched with the addicts. The dysfunctional attitudes scale and the coping strategies questionnaire was used to collect data. The two groups differed significantly in their dysfunctional attitudes and problem-focused and emotion-focused coping strategies. Substance-dependent individuals applied emotion-focused coping more and had greater dysfunctional attitudes than the healthy ones, and the latter applied problem-focused strategies more. Based on results, addicts have greater dysfunctional attitudes than non-addicts. Therefore, better treatment and rehabilitation results may be obtained by preparing grounds for appropriate psychological interventions and coping strategies in substance-dependent individuals.

Cui-yan W et al., (2017) [79] examined the relationships between dysfunctional attitudes, learned helplessness, and coping styles in a sample of 623 men with substance use disorders. They also explored the potential mediating effect of learned helplessness in the relationship between dysfunctional attitudes and coping styles. Participants completed the Dysfunctional Attitude Scale, Learned Helplessness Scale, and Coping Style Questionnaire. Results revealed that male drug abusers demonstrated dysfunctional attitudes and learned helplessness. In addition, dysfunctional attitudes and learned helplessness significantly predicted the coping styles of male drug abusers. However, although learned helplessness affected coping

styles, it did not mediate the relationship between dysfunctional attitudes and coping styles.

Horiuchi S et al., (2017) [80] examined whether the difference in perfectionistic dysfunctional attitudes between college students with subthreshold depression and those with no depression would be greater than that of dependent dysfunctional attitudes. Participants were defined as having subthreshold depression if they scored 16 or higher on the Japanese version of the Center for Epidemiologic Studies Depression Scale but did not meet the diagnostic criteria for a major depressive episode, as assessed by the major depressive episode module of the Mini-International Neuropsychiatric Interview. The participants included 21 male and 87 female college students, with a mean age of 20.3 years. Dysfunctional attitudes were evaluated with the Japanese version of the 24-item Dysfunctional Attitude Scale. Of the 108 students, 34 had subthreshold depression while 74 had no depression. The magnitudes of the differences in perfectionistic and dependent dysfunctional attitudes between the students with subthreshold depression and those with no depression were large (Cohen's d=0.83) and small (Cohen's d=0.25). The results of this study provide the first evidence that the difference in perfectionistic dysfunctional attitudes between college students with subthreshold depression and those with no depression is greater than that of dependent dysfunctional attitudes.

Bharati AS et al., (2017) [81] conducted a cross sectional study screening 152 patients with the diagnosis of alcohol dependence (DSM IV TR) for inclusion and exclusion criteria, out of which 60 patients were enrolled. Following scales were used, mechanisms of coping scale (MOCS), Hamilton anxiety rating scale (HAM-A), Montgomery-Asberg depression rating scale (MADRS). 32 patients had HAM-A score >17 suggestive of anxiety, similarly 40 patients had MADRS score >7 indicating depression. Problem focussed coping mechanism such as problem solving is associated with better outcome in terms of

lesser anxiety and later age of first drink as well as developing dependence. Passivity, which is an emotion focussed coping mechanism, is associated with earlier first drink and higher depression score in patient suggesting poor outcome. Coping skills training should be incorporated in abstinence focused programs. Co-morbid psychopathologies like anxiety and depression are common in alcohol dependence individuals and thus, screening for these symptoms is essential for early interventions and better outcomes.

Adan A et al., (2017) [82] examined the coping strategies related to treatment in substance use disorder (SUD) and SUD- major depressive disorder (MDD) patients and their associations with clinical characteristics. Forty SUD and 40 SUD-MDD males, each group composed by 20 therapeutic community and 20 ambulatory treatment patients, were assessed through the Coping Strategies Inventory and clinical characteristics questionnaires. SUD-MDD patients scored higher in Disengagement strategies such as Social Withdrawal and lower in Engagement ones such as Problem Solving, Cognitive Restructuring and Social Support, as well as in self-perceived capacity for coping. No differences for treatment were found. SUD and, specially, SUD-MDD patients scored higher than norms in maladaptive strategies. Time of abstinence, age of onset and severity of SUD were related to maladaptive coping. SUD and SUD-MDD patients are prone to employ Disengagement coping strategies and SUD-MDD patients coping repertory is more maladaptive than the SUD ones.

Hemanth NS &Starlet CTS (2018) [83] conducted a study to identify and compare the relationship between dysfunctional attitude and coping strategies among alcoholics under treatment. The sample for the study consisted of 60 alcoholics, who were consuming alcohol for more than 5 years & were taking treatment for more than 20 days. The age of the subjects ranged from 21 to 40 years. A personal data sheet was included with the questionnaire to collect data from the patients regarding their age, gender, educational status, socio economic status

and the alcohol related problems. The major tools used in the study are the Severity of Alcohol Dependence Questionnaire (SAD Q) by Edwards and Gross (1976), Dysfunctional attitude scale (DAS) by Arlene Weissman (1978), Coping Strategies Inventory (CSI) by David L Tobin (1984).The result shows that there is significant difference obtained among alcohol group based on age, relapse, family history, severity and duration of alcohol use. Correlation analysis reveals that there is significant positive correlation between severity of alcohol dependence, dysfunctional attitude and some variables of coping strategies inventory and negative correlation between severity of alcohol dependence and some sub variables of coping strategies inventory and between dysfunctional attitude and some variables of coping strategies inventory.

Yiğitoğlu GT & Keskin G (2019) [84] determined the relationship between dysfunctional beliefs and stress coping methods in drug-addicted patients. The population of this descriptive and cross-sectional research study comprised 51 patients who were admitted to the Alcohol and Drug Addiction Treatment Center of a state hospital, diagnosed with drug addiction, and consented to participate in our study. The data were collected by using the Socio-demographic Information Form, the Dysfunctional Attitude Scale (DAS), and the Coping Assessment Questionnaire (COPE). The average COPE score of the drug-addicted patients was found to be 171.60 ± 23.35. The average DAS score of the drug-addicted patients was determined to be 161.66 ± 36.94. A statistically significant difference was found between the DAS and COPE scores of the patients ($P < 0.05$). It can be concluded that these patients have dysfunctional beliefs and exhibit emotion-focused coping attitudes.

Karimi Z et al., (2019) [85] determined the role of attachment styles, dysfunctional attitudes, and spirituality in predicting membership in addicted and non-addicted groups, in a cross-sectional study conducted on 60 addicted people and 60 non-addicted people. The

Adult Attachment Scale of Hazan and Shaver, All port Religious Orientation Scale, and the 26-item Dysfunctional Attitude Scale (DAS-26) were used to measure the variables. Based on the results, which were analyzed by logistic regression analysis, the variables of attachment style and dysfunctional attitude can significantly predict drug addiction ($p < .001$). However, avoidant attachment style and spirituality cannot predict readiness for addiction. The results of this study indicate the importance of safe and ambivalent attachment styles and dysfunctional attitudes. Thus, attending to these factors in studies and interventions related to the treatment of substance abuse disorders is essential.

Rajabizadeh G et al., (2019) [86] conducted a descriptive and correlational study including the participants among all women on the verge of divorce with addicted husbands who referred to the forensic medicine and family court from October 2015 to March 2016. Thus, 190 individuals were selected using convenience sampling method. The researcher visited the study environment and after explaining the method and purpose of the study and obtaining informed consent from the subjects, distributed the questionnaires among the women. The questionnaire contained a demographic information form, the Dysfunctional Attitude Scale (DAS) (Weissman and Beck), and the Communication Patterns Questionnaire (CPQ) (Christensen and Sullawa). There was a significant and inverse relationship between dysfunctional attitudes and communication skills of women. In addition, a significant and inverse relationship was observed between dysfunctional attitudes and constructive interaction among women. Moreover, there was a direct and significant relationship between dysfunctional attitudes and the mutual avoidance relationship among women. Furthermore, a direct and significant relationship was found between dysfunctional attitudes and the expectation/isolation relationship among women. The findings of this study could be used in cognitive training of spouses, the correction of their dysfunctional attitudes, and improvement of their communication skills.

Barata CP et al., (2019) [87] reviewed the current evidence about substance use disorder and to answer two questions: “should Substance Addiction be conceptualized as a medical disorder, a morality flaw or an intermediate construct?” and “can individuals with substance use disorders be held responsible for their behavior and, if so, to what extent?” They found that, besides the psychiatry textbook, 38 studies met the inclusion criteria. Much of the scientific knowledge related with SA is in its early stages. Several risk factors were found to influence SA's development. SA's neurobiology includes several brain circuits and neurotransmitters. Drug consumption involves a series of voluntary acts; howbeit, its development is associated with enduring changes in brain function related to automatized behaviour. SA can be a major cause of morbidity and mortality. This suggests that, significant scientific evidence has been found not to consider SA as a simple morality flaw. Exclusively defining it as a medical diagnosis may be too short for its complexity, as a search for a broader multi-faceted perspective may be warranted. These individual's willpower and self-determination is not entirely preserved nor totally disrupted, and their accountability is a complex and not clear matter. Additional research is needed to further characterize SA and its mechanisms.

Heggeness LF et al., (2020) [88] designed a study to assess the interplay between depressive cognition, coping-oriented substance use, and future behavioral disengagement tendencies. Cognitive risk subtypes examined include brooding rumination, attributional bias (internal/stable/global), and dysfunctional attitudes. Individuals were recruited from outpatient treatment settings and met criteria for a unipolar depressive disorder (N = 70; 66% female; 81% White; Mage = 31; S Dage = 13.2). Participants completed self-report measures of brooding rumination, attributional style, dysfunctional attitudes, coping-oriented substance use, and behavioral disengagement tendencies following a 3-week period. Brooding rumination, stable attributional style, and dysfunctional attitudes were positively associated with later behavioral disengagement tendencies. Coping-oriented substance use

moderated associations between both internal attributional style, as well as dysfunctional attitudes onto later behavioral disengagement. With regard to stress-related avoidance, subsyndromal substance use may play a detrimental role among cognitively vulnerable, depressed outpatients when said drug or alcohol use serves as a means of coping.

Raftery D et al., (2020) [89] conducted a systematic review to synthesise and critically examine the existing literature on insight in substance use disorder (SUD). Included studies were on humans aged 18 years or over with SUD that examined the relationship between substance use and insight using a quantifiable measure of insight. Of 10,067 identified papers, 20 met the inclusion criteria, employing 13 different measures of insight. The most commonly used measure was the Hanil Alcohol Insight Scale (HAIS) which was the only measure designed for a substance use population and was specific to alcohol use. Based on a pooled sample from five studies (n = 585), 57% of participants had poor insight, 36% had fair insight, and 7% had good insight on the HAIS. Better insight was generally related to negative consequences from substance use, better treatment adherence and maintaining abstinence. Insight appears to be an important factor to consider within SUD. Exploring the most appropriate way to measure insight and assess its role in SUD has implications for intervention design, and engaging and maintaining people with SUD in treatment.

Wang GY (2022) [90] assessed the association between the level of expressed emotion (LEE) (i.e., criticism), coping style, and psychological distress (i.e., anxiety, depression) in people with substance use disorder (SUD). Compared to control subjects, persons with SUD reported less use of rational coping and detached coping, and perceived greater criticism and irritability from family. A higher degree of family criticism and lack of emotional support was associated with greater use of emotional and avoidance coping in persons with SUD, while psychological distress was more related to rational and

detached coping. The present study reveals the unique connection between family relationships, coping and psychological distress, implicating the need to address the influence of family relationships and stress on persons' coping in SUD treatment.

MATERIAL AND METHODS

STUDY PLACE: This study was carried out at Dayanand Medical College & Hospital, Ludhiana.

STUDY DESIGN: A prospective study.

STUDY PERIOD: Study was conducted for duration of 24 months after the approval of research committee and ethical committee.

SOURCE OF DATA: Study was conducted in the Department of Psychiatry, Dayanand Medical College & Hospital, Ludhiana (Punjab).

STUDY POPULATION: Study was conducted including 100 patients of substance dependence according to ICD10 criteria presenting to both inpatient and outpatient in Department of Psychiatry, DMCH, Ludhiana.

SAMPLE SIZE: 100 patients in the age group of 18-65years which were diagnosed as substance dependent according to ICD-10 and with 1 year period of dependence were evaluated. Dysfunctional attitudes and coping strategies scales were applied after getting approval of IEC (Institutional Ethical Committee).

INCLUSION CRITERIA:

1. Patients who are between 18 to 65 years of age.
2. Diagnosed cases of substance use as per ICD10.
3. Patient consuming substance for at least 1 year.
4. Subjects of either gender.
5. Patients who have given consent for the study.

EXCLUSION CRITERIA:

1. Patients below 18 years of age and above 65 years of age.
2. Substance dependent patients with intoxication, delirium, dementia, amnestic syndrome.
3. Substance dependent patients with other psychiatric co-morbidities such as depression, anxiety, psychosis, mania, mixed mania and depression or medical comorbidities like chronic liver disease, H.I.V, C.O.P.D, seizures.

4. Patients consuming other pharmaceutical substances such as pregabalins, codeine, gabapentin etc.
5. Patients with behavioural addiction.
6. Pregnant females with any substance use.

METHODOLOGY:

All included patients were subjected to detailed history taking on a preformed proforma. Dysfunctional Attitude Scale and Brief-COPE scores were noted.

1. Sociodemographic Proforma- It include name of patient, age, gender, marital status, number of children, occupation, education, address, contact number, the various substances used, duration of substance use, past history of any deaddiction treatment, history of any medical comorbidities like hypertension, Diabetes mellitus, Score on DAS scale.

2. Dysfunctional Attitude Scale- The DAS has been developed by Weissman and Beck. The Dysfunctional Attitude Scale (DAS Forms A and B) [69] was employed to assess the level of dysfunctional attitudes. In order to measure the beliefs and attitudes underlying different forms of psychopathology according to the Beck's cognitive theory. The 40 items of DAS-A are phrased as statements of underlying depressive idiosyncratic thinking. The 10 items are phrased in a functional way and 30 represent dysfunctional attitude. The score of the 40 questionnaire in 7 sub categories range is 40–280, and a high score indicates that the patient often exhibits dysfunctional attitudes. . DAS A and B have been reported to have high internal consistency, with .86 and .87 alphas coefficients respectively. -

The 4 factors of dysfunctional attitude scale are-
1. Performance evaluation
2. Need of approval
3. Autonomous attitude

4. Perfectionism [69]

3. The Brief-COPE(coping orientation of problem experienced)- is a 28 item self-report questionnaire designed to measure effective and ineffective ways to cope with a stressful life event. “Coping” is defined broadly as an effort used to minimize distress associated with negative life experiences. Avoidant Coping, which is characterized by the subscales of denial, substance use, venting, behavioral disengagement, self-distraction and self-blame. Approach Coping is characterized by the subscales of active coping, positive reframing, planning, acceptance, seeking emotional support, and seeking informational support. [67]

Scores are presented for the two overarching coping styles:

1. Avoidant coping
2. Approach coping

STATISTICAL ANALYSIS:

Data was described in terms of range; mean ±standard deviation (± SD), median, frequencies (number of cases) and relative frequencies (percentages) as appropriate. All statistical calculations were done using (Statistical Package for the Social Science) SPSS 21version (SPSS Inc., Chicago, IL, USA) statistical program.

OBSERVATIONS AND RESULT

Table 1: Age distribution

Age	No. of cases	Percentage
< 25	21	21.0%
26-30	33	33.0%
31-35	29	29.0%
36-40	12	12.0%
> 40	5	5.0%
Total	100	100.0%
Minimum	Maximum	Mean±SD
21 years	45 years	30.40±5.47

A prospective study was conducted including 100 patients of substance dependence according to ICD10 criteria presenting to both inpatient and outpatient in Department of Psychiatry, DMCH, Ludhiana, after considering the inclusion and exclusion criteria. The written informed consent for clinical examination was obtained from patient/attendant. Of the 100 subjects included in the study, maximum subjects were in age range 26-30 years (33%), followed by 29 subjects in age group 31-35 years, 21 subjects were <25 years of age, 12 subjects were between 36-40 years of age and only 5 patients were >40 years of age. The minimum age of the included subjects was 21 years and maximum age was 45 years. Mean age of the study subjects was 30.40±5.47 years. (Table 1)

Table 2: Gender distribution

Gender	No. of cases	Percentage
Male	100	100.0%

All the included subjects in the study were males. (Table 2)

Table 3: Marital Status

Marital status	No. of cases	Percentage
Unmarried	46	46.0%
Married	52	52.0%
Separated	2	2.0%
Total	100	100.0%

In present study, majority of the subjects were married (52%), followed by unmarried (46%) and only 2 subjects were separated. (Table 3)

Table 4: Education of study subjects

Education	No. of cases	Percentage
Matric	5	5.0%
Diploma	14	14.0%
Graduate	67	67.0%
Post graduate	14	14.0%
Total	100	100.0%

In present study, maximum subjects were educated till graduation (67%), followed by 14 subjects each in diploma group and in post graduate section and only 5 subjects had studied till matric. (Table 4)

Table 5: Occupation of study subjects

Occupation	No. of cases	Percentage
Unemployed/student	22	22.0%
Clerical/shop owner/farmer	35	35.0%
Semi-professional	42	42.0%
Professional	1	1.0%
Total	100	100.0%

As depicted in table 5, majority of subjects were Semi-professional (42%), 35 patients were either in Clerical job/shop owner/farmer, 22 patients were either unemployed or students and only one subject was Professional.

Table 6: Number of Children of the study subjects

Children	No. of cases	Percentage
0	61	61.0%
1	26	26.0%
2	11	11.0%
3	2	2.0%
Total	100	100.0%

As depicted inn table 6, maximum subjects had no children (61%), 26 subjects had one child, 11 subjects had 2 children, and only 2 subjects had 3 kids.

Table 7: Type of family

Type of family	No. of cases	Percentage
Nuclear	78	78.0%
Joint	22	22.0%
Total	100	100.0%

In present study, maximum subjects live in nuclear family (78%) and 22 subjects live in joint family. (Table 7)

Table 8: Area of residence of study subjects

Residence	No. of cases	Percentage
Rural	18	18.0%
Urban	82	82.0%
Total	100	100.0%

As depicted in table 8, majority of the subjects reside in urban area (82%) and only 18 subjects belonged to rural area.

Table 9: Socio-economic status of study subjects

Socio-economic status	No. of cases	Percentage
Middle class	82	82.0%
Upper class	18	18.0%
Total	100	100.0%

Maximum study subjects were from middle class (82%) and only 18 subjects were from upper class. (Table 9)

Table 10: Age of patient at which first consumed addictive substance

Age at which first consumed substance	No. of cases	Percentage
10-14	39	39.0%
15-19	31	31.0%
20-24	14	14.0%
25-29	16	16.0%
Total	100	100.0%

In present study, maximum subjects (39%) started consuming addictive substances at the age of 10-14 years, 31 subjects started consuming at age of 15-19 years, 14 subjects started consuming addictive products at age of 20-24 years and 16 patients started when they were aged between 25-29 years. (Table 10)

Table 11: Type of substance consumed

Type of substance consumed	No. of cases	Percentage
Alcohol, opioid, cannabinoids	1	1.0%
Alcohol, opioid, cannabinoids, tobacco	1	1.0%
Alcohol, opioid, tobacco	2	2.0%
Alcohol, cannabinoids	8	8.0%
Alcohol, cannabinoids, tobacco	1	1.0%
Alcohol, tobacco	11	11.0%
Alcohol, opioid, tobacco	1	1.0%
Opioid, cannabinoids	9	9.0%
Opioid, cannabinoids, tobacco	6	6.0%
Opioid, sedatives	1	1.0%
Opioid, sedatives, tobacco	3	3.0%
Opioid, cocaine, tobacco	3	3.0%
Opioid, hallucinogens, tobacco	3	3.0%
Opioid, tobacco	19	19.0%
Cannabinoids, stimulants, tobacco	1	1.0%
Cannabinoids, hallucinogens	1	1.0%
Cannabinoids, hallucinogens, tobacco	1	1.0%
Cannabinoids, tobacco	9	9.0%
Sedatives, tobacco	19	19.0%
Total	100	100.0%

In present study, 19 subjects each consumed either Sedatives and tobacco or Opioid and tobacco, 11 subjects consumed Alcohol and tobacco, 9 patients either consumed Opioid and cannabinoids or

Cannabinoids and tobacco, 8 subjects consumed Alcohol and cannabinoids, 6 patients consumed Opioid, cannabinoids and tobacco, 3 subjects either consumed Opioid, sedatives and tobacco or Opioid, cocaine and tobacco or Opioid, hallucinogens, tobacco. 2 subjects consumed Alcohol, opioid and tobacco. 1 subject each either consumed Alcohol, opioid and cannabinoids or Alcohol, opioid, cannabinoids and tobacco or Alcohol, cannabinoids and tobacco or Alcohol, opioid and tobacco or Opioid and sedatives or Cannabinoids, stimulants and tobacco or Cannabinoids and hallucinogens or Cannabinoids, hallucinogens and tobacco. (Table 11)

Table 12: Number of substances consumed

Number of substances consumed	No. of cases	Percentage
2	58	58.0%
3	38	38.0%
4	4	4.0%
Total	100	100.0%

Maximum of the study subjects (58%) consumed 2 addictive substances, 38 subjects consume 3 substances and 4 patients consumed 4 substances. (Table 12)

Table 13: Grades of Insight

Insight Grade	No. of cases	Percentage
3	45	45.0%
4	42	42.0%
5	13	13.0%
Total	100	100.0%

In present study, 45 subjects had insight grade 3, 42 patients grade was 4 and 13 subject had insight grade 5. (Table 13)

Table 14: Number of deaddiction attempts

Number of deaddiction therapies taken	No. of cases	Percentage
First	54	54.0%
1-5	46	46.0%
Total	100	100.0%

In present study, 54 subjects were taking deaddiction therapy for first time and 46 patients had taken 1-5 deaddiction therapy. (Table 14)

Table 15: Compliance of study subjects towards treatment

Compliance	No. of cases	Percentage
Yes	57	57.0%
No	43	43.0%
Total	100	100.0%

In present study, 57 subjects showed compliance towards treatment but 43 did not showed compliance. (Table 15)

Table 16: Family history of substance use

Family history of substance use	No. of cases	Percentage
Yes	53	53.0%
No	47	47.0%
Total	100	100.0%

In present study, 53 subjects had positive family history of substance use, whereas 47 subjects had no such history. (Table 16)

Table 17: Family history of any other mental illness

Family history of any other mental illness	No. of cases	Percentage
Yes	9	9.0%
No	91	91.0%
Total	100	100.0%

In present study, 9 subjects had positive family history of other mental illness, whereas 91 subjects had no such history. (Table 17)

Table 18: DAS SCORE

DAS SCORE	No. of cases	Percentage
Class I (<79) (very low)	0	0.0%
Class II (80-112) (low)	33	33.0%
Class III (113-142) medium)	17	17.0%
Class IV (143-169) (high)	38	38.0%
Class V (>170) (very high)	12	12.0%
Total	100	100.0%

In present study, majority of the subjects (38%) had high DAS score i.e., 143-169 suggesting of often patient had dysfunctional attitude and 12 subjects had very high DAS score (>170) which shows they almost all time show dysfunctional attitude, whereas 33 had low DAS score and 17 had Medium DAS score. (Table 18)

Table 19: DAS score distribution

DAS	Minimum	Maximum	Mean	SD
Perfectionist attitude	38.00	104.00	66.20	18.83
Need for approval	18.00	45.00	33.01	8.12
Independent attitude	10.00	41.00	25.49	8.84
Varied attitude	8.00	14.00	11.01	1.74
Total DAS score	86.00	190.00	135.74	31.00

In present study, Perfectionist attitude value range between 38.00-104.00 and the mean value was 66.20±18.83, Need for approval value range between 18.00-45.00 and the mean value was 33.01± 8.12, Independent attitude value range between 10.00-41.00 and the mean value was 25.49±8.84 and Varied attitude value range between 8.00-14.00 and the mean value was 11.01±1.74. The minimum total DAS score among study subjects was 86 and maximum was 190 and the mean value was 135.74±31.00. (Table19)

Table 20: Coping distribution

Variables	Mean	SD
Problem Focused Coping		
Use of informational support	11.94	2.05
Active coping	12.54	2.95
Restraint coping	10.41	2.38
Suppression of competing activities	11.13	2.37
Planning	13.04	2.88
Total	59.06	9.89
Emotion Focused Coping		
Positive reframing	12.63	2.11
Religion	14.06	3.14
Humour	8.68	3.42
Emotional Support	11.13	2.37

Acceptance	12.46	3.36
Total	58.96	10.77
Dysfunctional coping		
Mental disengagement	10.63	2.79
Behavioural Disengagement	8.90	2.32
Venting	11.67	2.71
Denial	8.28	2.77
Substance Use	14.77	2.99
Total	54.25	8.62
Brief -COPE total score	172.77	21.45

The mean Problem Focused Coping score was 59.06±9.89, Emotion Focused Coping was 58.96±10.77, Dysfunctional coping was 54.25±8.62. The average COPE score of the patients diagnosed with drug addiction was found to be 172.77±21.45. (Table 20)

Table 21: The relationship between the Dysfunctional Attitude Scale and COPE subscales

COPE and subscales	**DAS and subscales**									
	Perfectionist attitude		**Need for approval**		**Independent attitude**		**Varied attitude**		**DAS total**	
	r	***P***	***r***	***P***	***r***	***P***	***r***	***P***	***r***	***P***
Average scores from subscales										
Seeking social support for instrumental reasons	0.16	0.212	0.33	0.105	0.07	0.730	−0.17	0.310	0.190	0.170
Active coping	0.17	0.290	0.19	0.18	−0.11	0.490	−0.28	0.058	0.16	0.350
Restraint coping	0.06	0.170	0.14	0.351	−0.13	0.390	0.09	0.590	0.09	0.591
Suppression of competing activities	−0.19	0.900	−0.19	0.190	−0.290	0.020*	−0.07	0.562	−0.14	0.290
Planning	0.07	0.710	0.16	0.380	−0.15	0.350	−0.2	0.20	0.05	0.761
Problem-focused coping, total	0.14	0.290	0.17	0.210	−0.15	0.240	−0.21	0.170	0.13	0.421

COPE and subscales	DAS and subscales									
	Perfectionist attitude		Need for approval		Independent attitude		Varied attitude		DAS total	
	r	*P*	*r*	*P*	*r*	*P*	*r*	*P*	*r*	*P*
Positive reinterpretation and growth	0.13	0.390	0.22	0.140	0.05	0.770	−0.16	0.240	0.16	0.289
Turning to religion	0.27	0.080	0.30	0.030*	−0.04	0.840	−0.15	0.320	0.26	0.090
Humor	0.18	0.180	0.07	0.710	0.03	0.930	−0.28	0.090	0.15	0.391
Seeking emotional social support	0.17	0.200	0.21	0.130	0.14	0.350	0.07	0.690	0.25	0.090
Acceptance	0.28	0.070	0.23	0.130	−0.17	0.190	−0.15	0.260	0.21	0.180
Emotion-focused coping, total	0.30	0.010*	0.29	0.020*	0.01	0.920	−0.21	0.120	0.32	0.010*
Mental disengagement	0.32	0.010*	0.22	0.100	−0.11	0.480	−0.31	0.020*	0.24	0.070
Focus on and venting of emotions	−0.19	0.900	−0.23	0.089	−0.06	0.750	−0.05	0.780	−0.14	0.450
Denial	0.26	0.030*	0.22	0.150	−0.14	0.260	−0.18	0.180	0.22	0.130
Behavioral	−0.03	0.900	−0.13	0.450	0.02	0.920	0.03	0.920	−0.03	0.740

COPE and subscales	**DAS and subscales**									
	Perfectionist attitude		**Need for approval**		**Independent attitude**		**Varied attitude**		**DAS total**	
	r	***P***	***r***	***P***	***r***	***P***	***r***	***P***	***r***	***P***
disengagement										
Substance use	0.06	0.600	0.08	0.540	0.25	0.080	0.17	0.180	0.15	0.280
Dysfunctional coping, total	0.25	0.080	0.07	0.570	−0.02	0.910	−0.13	0.400	0.17	0.223
COPE, total	0.32	0.020*	0.25	0.080	−0.06	0.630	−0.26	0.110	0.26	0.070

A significant positive relationship was found between the perfectionist attitude subscale of the COPE scale of the patients and emotion-focused coping, dysfunctional coping attitudes of the mental disengagement subscale, denial subscale, and COPE total scale of the patients. Therewas a positive relationship between the need for approval subscale of the DAS and the religiously, ofemotion-focused coping subscale of the COPE.There was also a statistically significant positive relationship between DAS total scale and the emotion-focused coping subscale of COPE.

Table 22: Correlation between age and Total DAS score

Variables	r value	p value
Age and Total DAS score	0.15	0.14

In present study, it was found that with increase in age; DAS score also increases. Hence Pearson correlation analysis revealed positive correlation between age and DAS score, however relation was not statistically significant. (Table 22)

Table 23: Comparison of occupation according to DAS score

DAS Category		Occupation				Total
		Unemployed/student	Clerical/Shopowner/Farmer	Semiprofessional	Professional	
High Level	N	8	7	22	1	38
	%	36.4%	20.0%	52.4%	100.0%	38.0%
Low Level	N	12	17	4	0	33
	%	54.5%	48.6%	9.5%	0.0%	33.0%
Medium Level	N	2	5	10	0	17
	%	9.1%	14.3%	23.8%	0.0%	17.0%
Very High	N	0	6	6	0	12
	%	0.0%	17.1%	14.3%	0.0%	12.0%
Total	N	22	35	42	1	100
	%	100.0%	100.0%	100.0%	100.0%	100.0%
Chi Square		25.29				
p value		0.003*				

*: statistically significant

In present study, very high DAS score was found 50% in subjects who were doing clerical job/shop owner/farmer and 50% were semiprofessionals. Among 38 subjects with high DAS score 22 (57.89%) were semiprofessionals, 8 subjects were either unemployed or students, 7 were doing clerical job/shop owner/farmer and only 1 patient who was going a professional job had high score. When Chi Square test was applied to compare DAS score between subjects going different occupation, a significant relation was found between the DAS score and the occupation of the study subjects (p =0.003). (Table 23)

Table 24: Comparison of number of deaddiction therapies taken according to DAS score

DAS Category		No. of Deaddiction Therapies		Total
		First	1-5	
High Level	N	23	15	38
	%	42.6%	32.6%	38.0%
Low Level	N	23	10	33
	%	42.6%	21.7%	33.0%
Medium Level	N	7	10	17
	%	13.0%	21.7%	17.0%
Very High	N	1	11	12
	%	1.9%	23.9%	12.0%
Total	N	54	46	100
	%	100.0%	100.0%	100.0%
Chi Square		15.13		
p value		0.002*		

*: statistically significant

In present study, 11 (91.67%) subjects who had taken 1-5 therapies had very high DAS score and only 1 subject with first deaddiction therapy was in this group. In high DAS score group 23 (60.52%) subjects were those who had taken first deaddiction therapy and 39.47% (n=15) subjects were those who had taken 1-5 therapies. When Chi Square test was applied there was a statistically significant difference found between the no. of deaddiction therapies taken according to DAS score (p=0.002). (Table 24)

Table 25: Comparison of Family history of substance use according to DAS score

DAS Category		Family history of substance use		Total
		Yes	No	
High Level	N	23	15	38
	%	43.4%	31.9%	38.0%
Low Level	N	18	15	33
	%	34.0%	31.9%	33.0%
Medium Level	N	11	6	17
	%	20.8%	12.8%	17.0%
Very High	N	1	11	12
	%	1.9%	23.4%	12.0%
Total	N	53	47	100
	%	100.0%	100.0%	100.0%
Chi Square		11.44		
p value		0.01*		

*: statistically significant

In present study, in high DAS score group, 60.52% (n=23) were having positive family history of substance use and 39.47% (n=15) had no such history. In medium level group, 64.71% (n=11) had positive family history and 35.29% (n=6) had no such history. When chi square test was applied, it showed a statistically significant difference between the family history of substance use according to DAS score (p= 0.01). (Table 25)

DISCUSSION

Substance use problems are among the major contributors to the global disease burden, which includes disability and mortality. The benefits of treatment far outweigh the economic costs. Despite the availability of treatment services, however, the vast majorities of people with substance use disorders do not seek or use treatment but instead develop some dysfunctional attitude and a maladaptive coping mechanism to deal with the dependence. So present study was done to get all cards at one place to plan some further plan of action.

Following are the main findings of the study:

AsdescribedinTable1, out of the 100 subjects included in the study, maximum subjects were in age range 26-30 years (33%),followed by 29 subjects in age group 31-35 years,21 subjects were <25 years of age, 12 subjects were between 36-40 years of age and only 5 patients were >40 years of age. Though we enrolled the patients from age group 18-65 years, the mean age of study sample was found to be 30.40±5.47 years, with minimum age of the included subjects was 21 years and maximum age was 45 years. This shows that young individuals are more proneto substance abuse, may it be because of social pressure or stress due to economic reasons or family issues. This was similar to findings of other studies like by A'zami Y et al., (2015) [78], Bharati A Setal., (2017) [81], Yiğitoğlu GT & Keskin G (2019) [84] and Wang GY (2022). [90]

According to findings of A'zami Y et al., (2015) [78] mean and standard deviation of the participants' age was 25.09±4.17.

In study done by Yiğitoğlu GT & Keskin G (2019) [84] the average age of the patients who participated in the study was 35.13 ± 12.25 years. The maximum subjects (31.4%) were28-37 years of age.

According to study done by Bharati AS et al., (2017) [81], mean age of study subjects was 37.2±6.3 years.

In study done by Wang GY (2022) [90] mean age of subjects with substance use disorder was 35.5±8.2 years.

A study performed by Horiuchi S et al., (2017) [80] the participants included were with a mean age of 20.3 years.

As shown in table 2, all the included subjects in the study were males. The reason could be that addictive substance consumption by women is socially unacceptable in Indian culture and women may not avail treatment openly in a general hospital setting. Similar were the findings of the study done by Bharati A Setal.,(2017) [81] and Adan A et al., (2017) [82], they also showed that all included subjects in the study were males.

In study done by Yiğitoğlu GT & Keskin G (2019) [84] 90.2% of subjects were males.

As described in Table 3, majority of the subjects were married (52%), followed by unmarried (46%) and only 2 subjects were separated. Majority of participants were married, but this is not enough to draw any conclusion. The Indian society encourages marriage and traditionally women are supposed to be supportive of their spouses and only few of them opt for the separation or divorce from their spouse addiction related problems as found in present study that only two subjects were separated from their spouse.

According to study done by Bharati AS et al., (2017) [81], 75% of the study subjects were married.

In study done by Yiğitoğlu GT &Keskin G (2019) [84] maximum subjects were married (39.2%).

According to findings of Adan A et al., (2017) [82] substance use disorder (SUD) patients, 40% were Single, 17.5% had Stable partner, 22.5% were Married, 20% were Separated/divorced and no subject was Widower. And subjects of SUD- major depressive disorder (MDD),

45% were Single, 2.5% had Stable partner, 12.5% were married, 37.5% were Separated/divorced and 2.5% subject was Widower.

As seen in table 4, maximum subjects were educated till graduation (67%), followed by 14% subjects each in diploma group and in post graduate section and only 5% subjects had studied till matric. Education can also be a cause of stress and person leading towards substance use, when we did not get job according to our qualifications, or due to less income we are not able to meet the two ends of the life.

In study done by Bharati A Setal., (2017) [81], majority (66.6%) of subjects had studied till Intermediate.

According to findings of A'zami Y et al., (2015) [78] maximum (42%) study subjects had education till old system 6th grader or lower.

According to study done by Yiğitoğlu GT & Keskin G (2019) [84] maximum subjects (41.2%) have received only elementary schooling.

Table 5 describes that majority of subjects were Semi-professional (42%), 35% patients were either in Clerical job/shop-owner/farmer, 22% patients were either run employed or students and only one subject was Professional. This suggest that majority off the subjects in present study were doing jobs in which they are not highly paid, because of this stress and growing expenses of living in present scenario can also provoke subjects for substance use to just forget their problems for awhile.

According to study done by Yiğitoğlu GT &Keskin G (2019) [84] majority of the subjects were employed (45.1%).

Table 6 shows maximum subjects had no children (61%), 26 subjects had one child, 11 subjects had 2 children, and only 2 subjects had 3 kids. Having no child can also because of stress, as in Indian society it is considered desirable to have children and there is always a pressure from family and society to have children, which can also be supposed

to be a cause of subject to being provoked for substanceuse.

In study done by Yiğitoğlu GT &Keskin G (2019) [84] majority of study subjects (54.9%) have kids and 37.3% of patients have single child.

As depicted in Table 7and 8 in present study, maximum subjects live in nuclear family (78%) and 22 subjects live in joint family. The societal shift towards living in a nuclear family can also be a cause of stress because social and emotional support may be less. Also, some substance uses like alcohol, tobacco are considered acceptable by some. Majority of the subjects in present study, reside in urban area (82%) and only 18 subjects belonged to rural area. Since the subjects included in the study were those coming to medical college for treatment, so most of them belonged to urban area as the hospital is situated in the heart of the city.

In Table 9 maximum study subjects were from middle class (82%) and only 18 subjects were from upper class. Since the subjects included in present study were those coming to medical college, so it can be the reason that maximum of them were from middle class. The economic status of the subject may be a reason for subject's stress which in turn can lead to substance use.

According to study done by Bharati AS et al., (2017) [81], maximum (63.3%) patients belonged to Upper middle class, 10% were from Upper lower class and 26.6% were from Lower middle class.

According to findings of A'zami Y et al., (2015) [78] majority of subjects (43%) were from middle class, 28% were from lower class and 29% belonged to upper class.

Stress and dysfunctional thoughts are important determinants that lead individuals to start using substances or make them more addicted to drugs, stimulating worsening substance-abuse issues. In table 10 of present study, maximum subjects (39%) started consuming addictive substances at the age of 10-14 years, 31% subjects started consuming

at age of 15-19 years, 14% subjects started consuming addictive products at age of 20-24 years and 16% patients started when they were aged between 25-29 years. These findings suggest that using drugs at an early age increases the risk of being addicted. In the literature, it has been stated that 80% of drug-addicted individuals first used these drugs when they were younger than 18 years of age.[84]

In study done by Yiğitoğlu GT &Keskin G (2019) [84] majority of patients (52.9%) first used addictive substance at age between 16-20 years and 21.6% used at age of 11-15 years, these findings were almost similar to result of present study.

According to findings of Adan A et al., (2017) [82] substance use disorder (SUD) patients first consumed substance at mean age of 19.33 ± 6.52 years and subjects of SUD- major depressive disorder (MDD) mean age was 18.03 ± 6.48 years when they first consumed substances.

In study done by Bharati AS et al., (2017) [81] the mean age of first drink was 20.9±5.4 years with earliest age of first drink being 14 years and 22 of 60 participants had their first drink before 18 years of age.

In study done by Wang GY (2022) [90] mean age of subjects at which they first use substance was 13.7± 4.1 years, mean years of substance use was 15.1±7.7 and mean Days of abstinence was 450 ±898.

As depicted in Table 11, 19 subjects each consumed either Sedatives and tobacco or Opioid and tobacco, 11 subjects consumed Alcohol and tobacco, 9 patients either consumed Opioid and cannabinoids or Cannabinoids and tobacco, 8 subjects consumed Alcohol and cannabinoids, 6 patients consumed Opioid, cannabinoids and tobacco, 3 subjects either consumed Opioid, sedatives and tobacco or Opioid, cocaine and tobacco or Opioid, hallucinogens, tobacco. 2 subjects consumed Alcohol, opioid and tobacco. 1 subject each either consumed Alcohol, opioid and cannabinoids or Alcohol, opioid, cannabinoids and tobacco or Alcohol, cannabinoids and tobacco or

Alcohol, opioid and tobacco or Opioid and sedatives or Cannabinoids, stimulants and tobacco or Cannabinoids and hallucinogens or Cannabinoids, hallucinogens and tobacco.

According to findings of A'zami Y et al., (2015) [78] among the addicts, 29 used heroin, 13 used crystal meth and crack, 41 used opium and 17 used other substances.

In study done by Adan A et al., (2017) [82], they found that substance use disorder (SUD) patients use Alcohol (72.5%), Cocaine (75%), Cannabis (45%), Hallucinogen (7.5%), Opioid (5%) and Sedative (2.5%). And subjects of SUD- major depressive disorder (MDD), use Alcohol (87.5%), Cocaine (77.5%), Cannabis (35%), Hallucinogen (15%), Opioid (30%) and Sedative (20%).

In study done by Wang GY (2022) [90] among 42 subjects, 19 subjects use Methamphetamine, 12 were addicted to Alcohol consumption and 11 subjects had habit of Polydrug use like alcohol, methamphetamine, cannabis and opiates.

Table. 12 of present study, maximum of the study subjects (58%) consumed 2 addictive substances, 38 subjects consume 3 substances and 4 patients consumed 4 substances.

In study done by Wang GY (2022) [90] among 42 subjects, 73.81% subjects were addicted to only one substance and 26.19% subjects had habit of Polydrug use like alcohol, methamphetamine, cannabis and opiates.

Table 13 of present study depicts that, 45 subjects had insight grade 3, 42 patients grade was 4 and 13 subject had insight grade 5.

In study done by Raftery D et al., (2020) [89] they pooled sample from five studies (n = 585), 57% of participants had poor insight, 36% had fair insight, and 7% had good insight on the HAIS. Better insight was

generally related to negative consequences from substance use, better treatment adherence and maintaining abstinence.

In Table 14 of present study, 54% subjects were taking deaddiction therapy for first time and 46% patients had taken 1-5 deaddiction therapy.

According to study done by Yiğitoğlu GT &Keskin G (2019) [84] majority of subjects (47.1%) were taking therapy for the first time and 39.2% had taken 1-5 times earlier.

Table 15 of the study describes, 57 subjects showed compliance towards treatment but 43 did not showed compliance. This shows that majority of the patients were ready to leave the habit of substance abuse.

In present study table 16 depicts that, 53 subjects had positive family history of substance use, whereas 47 subjects had no such history. This shows that if a subject already had family history of substance use, than there are increased chance of them inculcating in these habits, as substance are easily available to the man sometimes there is less pressure from family to stop them from its use.

According to study done by Bharati A Setal., (2017) [81], 66.6% study subjects had positive family history of alcohol dependence.

In study done by Yiğitoğlu GT & Keskin G (2019) [84] majority of subjects (54.9%) had no family history of substance use.

In table 17 in present study, 9% subjects had positive family history of other mental illness, whereas 91% subjects had no such history. This suggests that positive family history of any other mental illness has no such effect on patient's life to promote him for substance abuse.

Majority of subjects (86.3%) had no history of psychological disease, in family in study done by Yiğitoğlu GT &Keskin G (2019) [84].

In present study table 18 and 19 shows that, majority of the subjects (38%) had high DAS score i.e., 143-169 suggesting of often patient had dysfunctional attitude and 12 subjects had very high DAS score (>170) which shows they almost all time show dysfunctional attitude, whereas 33 had low DAS score and 17 had Medium DAS score. Perfectionistattitudevaluerangebetween38.00-104.00 and the mean value was 66.20±18.83, Need for approval value range between 18.00 45.00 and the mean value was 33.01±8.12, Independent attitude value range between 10.00-41.00 and the mean value was 25.49±8.84 and varied attitude value range between 8.00-14.00 and the mean value was 11.01±1.74. The minimum DAS score among study subjects was 86 and maximum was 190 and the mean value was135.74±31.00.

The average score of the patients on the DAS was 161.66 ±36.94 and it ranged between 40- 280, according to research done by Yiğitoğlu GT & Keskin G (2019) [84].

In study done by Alizadeh K Hetal.,(2009) [76],they found that subject of substance abusers had experienced more stress, anxiety, depression, had shown a cognitively more percent of them dysfunctional attitudes in comparison with controlgroup.

According to findings of A'zami Y et al., (2015) [78], the mean of DAS for substance-dependent and healthy participants were 115.18±31.06.

In table 20 the mean Problem Focused Coping score was 59.06±9.89,Emotion Focused Coping was 58.96±10.77, Dysfunctional coping was 54.25±8.62. The average COPE score of the patients diagnosed with drug addiction was found to be172.77±21.45.

According to research done by Yiğitoğlu GT & Keskin G (2019) [84] the average COPE score of the patients diagnosed with drug addiction was found to be 171.60± 23.35.

In study done by Wang GY (2022) [90] mean Rational Coping score was 22.69±9.07, Detached Coping score was 18.33±7.32, Emotional

Coping was 20.02±9.43 and Avoidance Coping was 18.38±5.39.

In study done by Mohammed AS et al., (2017) [91] they found that 65% of the studied sample used emotion focused coping and 33% of them used less useful coping strategies. However, only 2% employed problem focused coping strategies. The mean score of coping strategieswas119.4±216.This indicates that, the studied sample were moderately use effective coping.

In study done by A'zami Y et al., (2015) [78] reported that, when addict patients faced with an environmental stressor they almost use inefficient/dysfunctional emotion-focused coping strategies such as increasing their substance abuse instead of problem-focused strategies and solving the problem leaving stressor not resolved.

In study done by Tofani H & Javanbakhat M (2001) [73] they found that during stressful period of life, substance abusers had weaker problem-solving strategies, cognitive evaluation and social support compared with control group.

In table 21, a significant positive relationship was found between the perfectionist attitude subscale of the COPE scale of the patients and emotion-focused coping, dysfunctional coping attitudes of the mental disengagement subscale, denial subscale, and COPE total scale of the patients. There was a significant positive relationship between the need for approval subscale of the DAS, the religiously coping subscale of the COPE, and the emotion-focused coping subscale. There was also a statistically significant positive relationship between DAS total scale and the emotion-focused coping subscale of COPE. The results of this study can be explained by saying that those who think irrationally are more prone to engage in risky behaviours like substance misuse. In other words, these attitudes are seen as dysfunctional since they are rigid, extreme, and resistant to change. Almost similar were the findings of Yiğitoğlu GT &Keskin G (2019) [84].

According to Ellis A (1991) [92] irrational beliefs and dysfunctional

attitude transform into the foundations of disruptive behavior. This philosophy is a compulsive thought, which is powerful, dry and dogmatic on one hand, and can lead to catastrophic interpretations on the other. Ellis has described this process as a vicious circle. They criticise themselves for their emotional disturbance before criticising themselves again. They keep trying to get psychotherapy, but eventually give up and realise there is nothing that can be done for them.

A study performed by Horiuchi S et al., (2017) [80] found that of the 108 students, 34 had subthreshold depression while 74 had no depression. The magnitudes of the differences in perfectionistic and dependent dysfunctional attitudes between the students with subthreshold depression and those with no depression were large (Cohen's d=0.83) and small (Cohen's d=0.25).

In study done by A'zami Yetal., (2015) [78] they found that addicts and control group differed significantly in their dysfunctional attitudes and problem-focused and emotion-focused coping strategies. Substance-dependent individuals applied emotion-focused coping more and had greater dysfunctional attitudes than the healthy ones, and the latter applied problem-focused strategies more. Addicts have greater dysfunctional attitudes thannon-addicts.

Another study performed by Cui-yan W et al., (2017) [79] found that male drug abusers demonstrated dysfunctional attitudes and learned helplessness. In addition, dysfunctional attitudes and learned helplessness significantly predicted the coping styles of male drug abusers. However, although learned helplessness affected coping styles, it did not mediate the relationship between dysfunctional attitudes and coping styles.

In study done by Adan A et al., (2017)[82], they found that substance use disorder (SUD) patients tend to a higher use, as compared to SUD- major depressive disorder (MDD), of Problem Solving (p=0.029),

Cognitive Restructuring (p=0.003) and Social Support (p=0.045), and they also showed a higher capacity to engage the problem (p=0.017). On the other hand, SUD-MDD patients exhibited a higher use of Social Withdrawal (p < 0.001). Regarding secondary scales, SUD patients showed a higher use of Problem Focused Engagement (p=0.003) and Emotion Focused Engagement (p=0.030), while SUD-MDD patients had a higher use of Emotion Focused Disengagement (p=0.005). Finally, attending to tertiary scales, SUD patients displayed a higher use of Engagement strategies (p=0.004) while SUD-MDD showed a higher use of Disengagement strategies (p=0.030).

In study done by Mohammed AS et al., (2017) [91] they found that there was significant positive correlation between coping strategies and quality of life QoL among total patients which indicates using effective coping strategies improve quality of life. This finding of Mohammed AS et al., (2017) [91] could be explained in the light of the psychological concept of coping is associated with stress which is considered commonly related to all HRQoL domains that generate distress to an individual. As a result, individuals develop coping strategies to manage stress or health problems as well as to improve their overall quality of life QoL.

As depicted in table 22, 23, 24 and 25 of present study, it was found that with increase in age; DAS score also increases. Hence, Pearson correlation analysis revealed positive correlation between age and DAS score, however relation was not statistically significant. Very high DAS score was found 50% in subjects who were doing clerical job/shop owner/farmer and 50% were semiprofessionals. Among 38 subjects with high DAS score 22 (57.89%) were semiprofessionals, 8 subjects were either unemployed or students, 7 were doing clerical job/shop owner/farmer and only 1 patient who was going a professional job had high score. When Chi Square test was applied to compare DAS score between subjects going different occupation, a significant relation was found between the DAS score and the occupation of the study subjects

(p =0.003). 11 (91.67%) subjects who had taken 1-5 therapies had very high DAS score and only 1 subject with first deaddiction therapy was in this group. In high DAS score group 23 (60.52%) subjects were those who had taken first deaddiction therapy and 39.47% (n=15) subjects were those who had taken 1-5 therapies. When Chi Square test was applied there was a statistically significant difference found between the no. of deaddiction therapies taken according to DAS score (p=0.002). In high DAS score group, 60.52% (n=23) were having positive family history of substance use and 39.47% (n=15) had no such history. In medium level group, 64.71% (n=11) had positive family history and 35.29% (n=6) had no such history. When chi square test was applied, it showed a statistically significant difference between the family history of substance use according to DAS score (p= 0.01).

Almost similar were the findings of Yiğitoğlu GT &Keskin G (2019) [84], they found no statistically significant difference between the average DAS score and subscale scores of the patients depending on their age. They found a significant difference between the “average independent attitude” subscale score of DAS according to the occupations of the patients (KW=11.25, P= 0.020).

In study done by Calache J et al., (1994) [72], they found that both depressed and non- depressed substance abusers had significantly higher DAS scores than controls. Depressed substance abusers had higher scores than non-depressed substance abusers. There was no correlation between age, sex, age of onset or the nature of the substance used and DAS scores in either group of patients. There was a trend for an elevation of DAS scores with chronicity of dependence among depressed substance abusers. This result supports the hypothesis of the presence of maladaptive thinking patterns among substance abusers, and suggest a need for further exploration of their cognitive styles and of the use of cognitive therapy in the treatment of addiction.

In study done by Barata CP et al., (2019)[87], they found that the earlier

a person begins to experiment with drugs or alcohol, the more likely he or she will develop an addiction. Adolescence is a particular vulnerable period due to a number of psychological traits, such as risky and reward seeking behaviour that adolescents exhibit, but also due to the harmful effect that drugs can have on the developing brain. Drug use tends to be at a maximum prevalence during emerging adulthood, peaking at ages 21-22. Emerging adults may feel particularly invulnerable to negative life consequences, be self-interested or even hedonistic, and so, more likely to engage in risky behaviours, being relatively more frequently exposed to addiction-related settings (e.g., raves). They also found that, home life can heighten a child's risk for later alcohol or drug problems. Several factors play an important role: living with someone (a parent or significant other) who abuses alcohol or drugs, abusive or neglectful parents, childhood adversity and ineffective parenting.

Another study performed by Hemanth NS & Starlet CTS (2018) [83] found that there is significant difference obtained among alcohol group based on age, relapse, family history, severity and duration of alcohol use. Correlation analysis reveals that there is significant positive correlation between severity of alcohol dependence, dysfunctional attitude and some variables of coping strategies inventory and negative correlation between severity of alcohol dependence and some sub variables of coping strategies inventory and between dysfunctional attitude and some variables of coping strategies inventory.

In study done by Wang GY (2022) [90] they found that a higher degree of family criticism and lack of emotional support was associated with greater use of emotional and avoidance coping in persons with SUD, while psychological distress was more related to rational and detached coping. They revealed the unique connection between family relationships, coping and psychological distress, implicating the need to address the influence of family relationships and stress on persons' coping in SUD treatment. This suggests that family support plays a

very important role in life of subject who is addicted to substanceuse.

Wang GY (2022) [90] also found that age onset of substance use, and length of abstinence also play a role in persons ‘coping. These finding suggest that early exposure to the substance is associated with greater use of maladaptive coping, while drug abstinence is likely to help to reduce this tendency. This might be related to the negative impact of substance intoxication and withdrawal syndrome on emotional vulnerability and cognition. [2] With a period of abstinence maintenance, some of the deficits might be reduced. Improved coping skills have also been reported in patients undertaking SUD treatment. [69]

Negative thoughts and feelings are frequently brought on by dysfunctional beliefs and behaviours. This study discovered that having a perfectionism mindset was linked to coping strategies including mental disengagement. A cognitive model known as perfectionism is characterised by having high expectations and worrying excessively about making mistakes. Numerous psychopathologies are linked to perfectionism. Perfectionists are more likely to develop psychopathology due to dysfunctional cognitive traits linked to stress expectations, emergency situations, as well as the onset and maintenance of stress. In actuality, perfectionists tend to experience more stress. Additionally, dysfunctional attitudes in addicts are said to include perfectionism that cannot bewell-adjusted.

On the other hand, it was also discovered that participants in this study had higher scores on the need for approval scale, which is thought to be associated with pleasure for a person who depends on the support and acceptance of others. Failure to win others' acceptance could be interpreted as a threat that compromises a person's integrity. This dysfunctional attitude sets off negative ideas about the self, the outside world, and the future, which in turn creates depression symptoms. Addiction may be the primary factor causing this demand for other people's acceptance.

The need for DAS approval and the COPE subscales measuring turning to religion and emotion-focused coping were found to be positively correlated in this study. People who are anxious about their relationships with others may hold back on speaking their minds out of a need for acceptance and a fear of being rejected. This makes it impossible for people to know what other people are feeling, which can make them feel ununderstood and cause social anxiety. A greater desire to be accepted by others and expectations of not being rejected are closely tied to the need for acceptance, which is a key sign of interpersonal sensitivity.

An emphasis on emotions is what is meant by turning to religion. Under stressful circumstances, a person may gravitate toward religious rituals for a variety of reasons. Many people view religion as a source of emotional comfort. By enabling people to view difficult circumstances favourably, it may aid people in coping with unfavourable circumstances. Dueto their inability to get what they want from other people, drug addicts may find that religious rituals satisfy their desire for acceptance and support.

LIMITATIONS

The study has a few limitations-

1. The study's small sample size and all of the subjects were male.

2. The study was done in a tertiary care hospital of Punjab.

3. The findings of the study cannot be generalised for the entire population as it might not represent all the substance dependent patients in all societies because it only included individuals who have been treated inpatient and outpatient in the hospital.

SUMMARY AND CONCLUSION

The present prospective study was conducted in the Department of Psychiatry, DMCH, Ludhiana, after approval of the research review board, including 100 patients of substance dependence according to ICD 10 criteria, after considering the inclusion and exclusion criteria. The study protocol for all procedures was approved by the Institutional Review Board for Ethical Clearance of Dayanand Medical College & Hospital, Ludhiana. All subject/attendants were explained about the study and were asked to sign a written consent prior to commencement of the study. The information regarding each patient was kept confidential and was not revealed at any point of time. The recruited patients were subjected to detailed history taking on a preformed proformas. Dysfunctional Attitude Scale and Brief-COPE scores were noted.

Following are the main inferences of the present research work:

1. Maximum subjects were in age range 26-30 years (33%), followed by 29 subjects in age group 31-35 years, 21 subjects were <25 years of age, 12 subjects were between 36-40 years of age and only 5 patients were >40 years of age. The minimum age of the included subjects was 21years and maximum age was 45 years. Mean age of the study subjects was 30.40±5.47years.
2. All study subjects were males and majority of the study subjects were married (52%), followed by unmarried (46%) and only 2 subjects were separated. Maximum subjects were educated till graduation (67%), followed by 14 subjects each in diploma group and in postgraduate section and only 5 subjects had studied till matric. Majority of subjects were Semi-professional (42%), 35 patients were in Clerical job/shop owner/farmer, 22 patients were either unemployed or students and only one subject was Professional.
3. Maximum subjects had no children (61%), 26 subjects had one child, 11 subjects had 2 children, and only 2 subjects had 3kids. Maximum

study subjects live in nuclear family (78%) and 22 patients live in joint family. Majority of the subjects reside in urban area (82%) and only 18 subjects belonged to rural area. Maximum study subjects belonged to middle class (82%) status and only 18 subjects were from upper class.

4. Maximum study subjects (39%) started consuming addictive substances at the age of 10-14 years, 31 subjects started consuming at age of 15-19 years, 14 subjects started consuming addictive products at age of 20-24 years and 16 patients started when they were aged between 25-29years.Majority of subjects (19) each consumed either Sedatives and tobacco or Opioid and tobacco,11subjects consumed Alcohol and tobacco,9 patients either consumed Opioid and cannabinoids or Cannabinoids and tobacco, 8 subjects consumed Alcohol and cannabinoids,6 patients consumed Opioid, cannabinoids and tobacco,3 subjects either consumed Opioid, sedatives and tobacco or Opioid, cocaine and tobacco or Opioid, hallucinogens, tobacco. 2 subjects consumed Alcohol, opioid and tobacco. 1 subject each either consumed Alcohol, opioid and cannabinoids or Alcohol, opioid, cannabinoids and tobacco or Alcohol, cannabinoids and tobacco or Alcohol, opioid and tobacco or Opioid and sedatives or Cannabinoids, stimulants and tobacco or Cannabinoids and hallucinogens or Cannabinoids, hallucinogens and tobacco.
5. Maximum of the study subjects (58%) consumed 2 addictive substances, 38 subjects consume 3 substances and 4 patients consumed 4substances.45 subjects had insight grade 3, 42 patients grade was 4 and 13 subject had insight grade 5.54 subjects were taking deaddiction therapy for first time and 46 patients had taken 1-5 deaddiction therapy.57 subjects showed compliance towards treatment but 43 did not showedcompliance.53 subjects had positive family history of substance use, whereas 47 subjects had no such history. Only 9 subjects had positive family history of the mental illness, whereas 91 subjects had no such history.
6. Majority of the subjects (38%) had high DAS scorei.e.,143-169

and12%subjects had very high DAS score (>170), whereas 33% had low DAS score and 17% had Medium DAS score. Perfectionist attitude value range between 38.00-104.00 and the mean value was 66.20±18.83, Need for approval value range between 18.00-45.00 and the mean value was 33.01±8.12, Independent attitude value range between 10.00-41.00 and the mean value was 25.49±8.84 and varied attitude value range between 8.00-14.00 and the mean value was 11.01±1.74. The minimum total DAS score among study subjects was 86 and maximum was 190 and the mean value was135.74±31.00.

7. The mean Problem Focused Coping score was 59.06±9.89, Emotion Focused Coping was 58.96±10.77, Dysfunctional coping was 54.25±8.62. The average COPE score of the patients diagnosed with drug addiction was found to be172.77±21.45.There was also a statistically significant positive relationship between DAS total scale and the emotion-focused coping subscale of COPE.
8. It was found that with increase in age; DAS score also increases. On comparison of DAS score with occupation, 38 subjects were in high DAS score category out of which 22 (57.89%) were semiprofessionals, 8 subjects were either unemployed or students, 7 were doing clerical job/shop owner/farmer and only 1 patient who was going a professional job had high score. When Chi Square test was applied to compare between DAS score and subjects of different occupation a significant p value of 0.003 was obtained
9. On comparison of DAS score with de addiction attempts, in very High Das score category 11 (91.67%) subjects had taken 1-5 deaddiction attempts and only 1 subject with first de addiction attempt was in the group. In High DAS Score group 23(42.6%) subjects were those who had taken first de addiction attempt and 15 (32.6%) had taken 1-5 de addiction attempts. Chi Square test was applied to compare between number of de addiction attempts to DAS score a p value of 0.002 was obtained.
10. On comparison of DAS score with Family history, in high DAS score group, 60.52% (n=23) were having positive family history of

substance use and 39.47% (n=15) had no such history. In medium level DAS score group, 64.71% (n=11) had positive family history and 35.29% (n=6) had no such history. When chi square test was applied to compare between family history of substance and DAS score significant p value of 0.01 was obtained

CONCLUSION

In the current study, it was discovered that there was a strong positive association between the patients' COPE scale's perfectionist attitude subscale and their emotion-focused coping, dysfunctional coping attitudes, mental disengagement subscale, denial subscale, and COPE overall scale. The DAS's desire for approval subscale, the COPE's religious coping subscale, and the DAS's emotion-focused coping subscale all showed a strong positive association. Additionally, there was a statistically significant positive connection between the DAS total scale and the COPE subscale measuring emotion-focused coping. Drug and alcohol abuse is a widespread issue that typically affects children and young people and leads to major physical, social, and health-related issues. Although there are many different types of misused drugs, cannabis is still the most popular one. The threat of substance abuse, particularly among adolescents, is growing as a result of social and economic issues and the accessibility of substances. The primary effects of substance usage have been highlighted in this review, together with fully developed remedies to the issues. The main preventive techniques have also been thoroughly explained. Drug misuse issues are typically addressed through a variety of tactics, including public awareness campaigns, educational approaches, school-based, and community-based programmes. However, in patients who are physiologically drug dependent, patient management may be necessary.

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KEY TO MASTER CHART

SEX

0 - MALE

1 - FEMALE

MARITAL STATUS

0 - UNMARRIED

1 - MARRIED

2 - SEPARATED

3 - DIVORCED

EDUCATION

0 - PRIMARY

1 - MIDDLE

2 - MATRIC

3 - DIPLOMA

4 - GRADUATE

5 - POSTGRADUATE

OCCUPATION

0 - UNEMPLOYED/STUDENT

1 - RETIRED

2 - HOUSEWIFE/HOUSEHOLD

3 - SKILLED/SEMISKILLED/UNSKILLED WORKER

4 - CLERICAL/SHOPOWNER/FARMER

5 - SEMIPROFESSIONAL

6 - PROFESSIONAL

TYPE OF FAMILY

0 - LIVING ALONE

1 - NUCLEAR

2 - JOINT

RESIDENCE

0 - RURAL

1 - URBAN

SOCIO-ECONOMIC STATUS

0 - LOWER

1 - MIDDLE

2 - UPPER

AGE AT WHICH FIRST CONSUMED SUBSTANCE (Years)

0 - <10

1 - 010-14

2 - 15-19

3 - 20-24

4 - 25-29

5 - 30-34

6 - >34

TYPE OF SUBSTANCES CONSUMED

0 - ALCOHOL

1 - OPIOID

2 - CANNABINOIDS

3 - SEDATIVES

4 - COCAINE

5 - STIMULANTS

6 - HALLUCINOGENS

7 - TOBACCO

8 - VOLATILE SOLVENTS

DURATION OF SUBSTANCE USE (YEARS)

0 - 1-500

1 - 6-100

2 - 11-150

3 - >15

NUMBER OF DEADDICTION THERAPIES TAKEN

0 - FIRST

1 - 1-500

2 - >5

COMPLIANCE

0 - YES

1 - NO

FAMILY HISTORY OF SUBSTANCE USE

0 - YES

1 - NO

FAMILY HISTORY OF ANY OTHER MENTAL ILLNESS

0 - YES

1 - NO

GRADE OF DYSFUNCTION ON DAS

0 - VERY LOW (<79)

1 - LOW (80-112)

2 - MEDIUM (113-142)

3 - HIGH (143-169)

4 - VERY HIGH (>170)

S.No	Age	Gender	Marital status	Education	Occupation	Children	Type of family	Residence	Socio-economic status	Age at which first consumed substance	Type of Substance consumed	Number of substances consumed	Insight Grade	Number of deaddiction therapies taken	Compliance
1	32	0	0	4	4	0	1	1	1	2	1,7	2	4	0	0
2	26	0	1	3	5	0	1	1	1	1	0,7	2	3	0	0
3	33	0	0	4	5	0	1	1	1	2	2,7	2	3	1	1
4	28	0	0	4	5	0	1	1	1	2	0,2	2	4	1	1
5	42	0	1	4	4	2	2	0	1	1	1,7	2	3	1	1
6	33	0	0	5	5	0	1	1	2	1	1,2	2	4	1	1
7	25	0	0	4	0	0	2	1	1	1	3,7	2	4	0	0
8	28	0	1	4	5	1	1	1	1	2	1,2,7	3	3	0	0
9	30	0	1	4	4	1	1	1	1	2	0,2	2	3	1	1
10	37	0	1	3	4	2	1	0	1	3	0,1,7	3	4	1	1
11	35	0	1	4	5	1	1	1	1	2	1,3,7	3	3	1	1
12	22	0	0	2	0	0	2	0	1	3	0,7	2	5	0	0
13	40	0	1	3	4	1	2	1	1	3	1,4,7	3	3	1	1
14	32	0	1	4	5	0	1	1	1	4	1,6,7	3	4	0	0
15	28	0	1	4	4	0	1	0	1	2	2,7	2	4	0	0
16	31	0	1	5	5	1	1	1	2	3	1,7	2	3	0	0
17	27	0	0	4	4	0	2	0	1	3	2,7	2	3	1	1
18	31	0	1	4	6	1	2	1	2	2	3,7	2	3	1	0
19	32	0	0	4	5	0	1	1	1	1	0,7	2	4	0	0
20	44	0	2	3	5	1	2	1	1	1	0,1,2,7	4	3	1	0
21	25	0	1	4	0	0	1	1	1	2	1,2,7	3	4	0	0
22	21	0	0	5	0	0	1	1	1	1	1,7	2	4	0	0
23	33	0	1	4	4	0	1	1	1	1	0,7	2	3	0	0
24	30	0	1	3	4	2	1	0	1	2	1,7	2	3	1	1
25	25	0	0	2	0	0	1	1	1	2	0.1,7	3	4	0	0
26	40	0	1	4	4	3	1	1	2	4	2,7	2	3	0	0
27	28	0	0	4	5	0	2	1	1	3	0,7	2	4	0	0
28	30	0	1	4	5	1	1	1	1	4	0,2,7	2	3	0	0
29	37	0	1	3	5	1	1	0	1	4	2,6,7	3	4	1	1
30	35	0	1	4	4	1	1	1	2	4	1,3,7	3	5	1	1
31	42	0	1	4	5	2	1	1	2	2	2,5,7	3	3	1	1
32	40	0	1	5	5	2	1	0	1	3	2,7	2	4	0	0
33	32	0	1	4	5	1	1	1	1	4	1,2	2	3	0	0
34	30	0	0	4	4	0	2	0	1	3	0,2	2	3	1	1
35	25	0	1	4	0	0	1	1	1	3	0,1,7	3	3	0	0
36	36	0	1	3	4	2	1	0	1	3	1,2	2	4	1	1
37	35	0	1	4	5	1	1	1	1	2	3,7	2	3	1	1

S.No	Family history of substance use	Family history of any other mental illness	Total DAS score	DAS- Performance evaluation	DAS- Need for approval	DAS- Autonomous attitude	DAS- Perfectionism	Grade of dysfunction on DAS	Brief -COPE total score	Problem focussed total
1	0	1	126	62	38	14	12	2	57	17
2	1	1	102	42	21	30	9	1	62	17
3	0	1	160	68	42	37	13	3	62	18
4	1	1	190	98	40	41	11	4	63	16
5	0	1	144	64	37	29	14	3	63	20
6	0	1	125	53	34	28	10	2	55	16
7	1	1	98	40	23	27	8	1	57	20
8	1	1	166	82	41	31	12	4	59	18
9	0	1	137	58	37	31	11	3	63	20
10	0	1	158	85	32	29	12	3	59	21
11	0	1	154	68	39	33	14	3	59	17
12	1	0	92	50	18	13	11	1	51	17
13	1	1	180	97	35	38	10	4	56	16
14	0	1	156	82	43	18	13	3	56	20
15	0	1	136	56	37	31	12	2	58	18
16	0	0	105	43	22	26	14	1	56	22
17	0	1	161	79	41	28	13	3	56	19
18	1	1	165	86	43	25	11	3	56	16
19	0	1	158	75	38	35	10	3	62	18
20	1	1	122	58	34	22	8	2	66	19
21	0	1	93	45	27	11	10	1	55	19
22	1	1	147	71	38	29	9	3	51	15
23	0	1	106	49	31	15	11	1	54	19
24	1	0	178	104	38	22	14	4	58	18
25	0	1	113	61	19	23	10	2	58	20
26	0	1	163	92	39	19	13	3	52	15
27	0	1	146	67	45	25	9	3	56	15
28	1	1	131	76	32	12	11	2	52	21
29	1	1	139	84	18	25	12	2	58	18
30	0	1	86	46	18	11	11	1	52	16
31	1	1	139	55	42	31	12	2	60	20
32	0	1	118	66	18	23	11	2	49	16
33	0	1	168	102	38	14	14	3	59	23
34	1	1	102	51	31	10	10	1	56	21
35	1	1	134	76	32	17	9	2	59	23
36	0	1	158	85	32	29	12	3	59	21
37	0	1	154	68	39	33	14	3	59	17

S.No	Active coping	Use of informational support	Positive reframing	Planning	Emotion focussed total	Emotional Support	Venting	Humour	Acceptance	Self-blame	Religion	Avoidant total	Self-distraction	Substance Use	Denial	Behavioural disengagement
1	3	3	5	6	22	3	3	2	6	6	2	18	6	4	4	4
2	4	2	6	5	24	4	4	4	5	5	2	21	7	6	5	3
3	4	4	4	6	22	3	2	3	6	5	3	22	7	6	4	5
4	3	3	5	5	25	4	3	3	4	7	4	22	5	6	5	6
5	5	5	4	6	24	5	2	3	5	7	2	19	5	5	4	5
6	5	3	4	4	22	3	3	2	5	6	3	17	4	6	3	4
7	6	4	5	5	23	3	4	2	6	4	4	14	4	6	2	2
8	5	4	4	5	23	4	3	3	5	5	3	18	5	5	3	5
9	4	5	5	6	25	5	4	4	4	5	3	18	5	6	3	4
10	4	6	4	7	22	3	3	3	4	5	4	16	4	6	2	4
11	6	4	3	4	23	4	2	3	5	6	3	19	6	7	3	3
12	5	3	4	5	20	3	3	2	5	4	3	14	6	2	4	2
13	4	3	4	5	23	4	3	3	4	7	2	17	5	6	2	4
14	5	6	3	6	21	3	2	3	4	4	5	15	6	3	3	3
15	4	5	5	4	24	4	3	3	5	5	4	16	5	4	3	4
16	5	6	6	5	20	3	3	3	5	3	3	14	5	4	3	2
17	5	5	5	4	18	3	2	2	4	5	2	19	7	6	2	4
18	4	3	6	3	21	3	2	2	4	7	3	19	6	4	4	5
19	3	6	5	4	22	3	3	2	4	7	3	22	7	5	4	6
20	6	4	4	5	27	4	4	4	6	7	2	20	6	5	4	5
21	7	4	4	4	20	4	3	3	3	4	3	16	5	5	3	3
22	4	3	4	4	20	4	4	2	3	5	2	16	5	4	2	5
23	5	5	3	6	21	5	4	3	3	3	3	14	4	5	2	3
24	4	4	5	5	23	3	4	3	5	5	3	17	4	4	3	6
25	6	5	2	7	22	4	3	3	5	5	2	16	5	5	2	4
26	3	4	4	4	22	4	3	3	4	6	2	15	4	3	3	5
27	5	5	2	3	23	3	4	3	6	5	2	18	5	4	4	5
28	4	4	6	7	19	3	2	2	4	5	3	12	4	2	4	2
29	4	3	5	6	25	3	5	3	5	6	3	15	5	3	4	3
30	4	3	4	5	20	4	3	3	5	3	2	14	5	4	3	2
31	6	4	5	5	21	4	3	2	4	5	3	19	6	5	4	4
32	5	3	4	4	20	3	4	3	3	4	3	13	4	2	4	3
33	6	5	5	7	21	4	4	2	6	2	3	15	5	3	4	3
34	5	4	6	6	20	3	4	3	6	2	2	15	5	4	4	2
35	6	6	6	5	21	3	3	3	4	5	3	15	4	4	3	4
36	4	6	4	7	22	3	3	3	4	5	4	16	4	6	2	4
37	6	4	3	4	23	4	2	3	5	6	3	19	6	7	3	3

S.No	Age	Gender	Marital status	Education	Occupation	Children	Type of family	Residence	Socio-economic status	Age at which first consumed substance	Type of Substance consumed	Number of substances consumed	Insight Grade	Number of deaddiction therapies taken	Compliance
38	23	0	0	2	0	0	2	0	1	3	1,7	3	5	0	0
39	26	0	1	3	5	0	1	1	1	1	0,1,2	2	3	0	0
40	33	0	0	4	5	0	1	1	1	2	3,7	3	3	1	1
41	28	0	0	4	5	0	1	1	1	2	0,2	3	4	1	1
42	21	0	0	5	0	0	1	1	1	1	3,7	3	4	0	0
43	25	0	1	4	4	0	1	1	1	1	1,2	4	3	0	0
44	32	0	0	4	5	0	1	1	1	1	3,7	2	4	0	0
45	45	0	2	3	5	1	2	1	1	1	1,6,7	2	3	1	0
46	40	0	1	4	4	3	1	1	2	4	2,6	3	3	0	0
47	32	0	0	4	5	0	1	1	1	2	2,7	2	3	1	1
48	29	0	0	4	5	0	1	1	1	2	0,2	2	4	1	1
49	41	0	1	4	4	2	2	0	1	1	1,7	2	3	1	1
50	30	0	0	5	5	0	1	1	2	1	1,2	2	4	1	1
51	27	0	0	4	0	0	2	1	1	1	3,7	2	4	0	0
52	24	0	0	5	0	0	1	1	1	1	1,7	2	4	0	0
53	28	0	1	4	4	0	1	1	1	1	0,7	2	3	0	0
54	30	0	1	3	4	2	1	0	1	2	1,7	2	3	1	1
55	21	0	0	5	0	0	1	1	1	1	3,7	3	4	0	0
56	27	0	1	4	4	0	1	1	1	1	1,2	4	3	0	0
57	24	0	0	5	0	0	1	1	1	1	3,7	3	4	0	0
58	29	0	1	4	4	0	1	1	1	1	1,2	4	3	0	0
59	27	0	0	4	0	0	2	1	1	1	3,7	2	4	0	0
60	28	0	1	4	5	1	1	1	1	2	1,2,7	3	3	0	0
61	35	0	1	4	4	1	1	1	2	4	1,3,7	3	5	1	1
62	37	0	1	4	4	1	1	1	2	4	2,7	3	5	1	1
63	25	0	0	4	0	0	2	1	1	1	3,7	2	4	0	0
64	28	0	1	4	5	1	1	1	1	2	1,2,7	3	3	0	0
65	35	0	0	4	5	0	1	1	1	2	3,7	3	3	1	1
66	26	0	0	4	5	0	1	1	1	2	0,2	3	4	1	1
67	32	0	0	4	5	0	1	1	1	1	1,7	2	4	0	0
68	36	0	1	4	4	1	1	1	2	4	3,7	3	5	1	1
69	24	0	0	2	0	0	2	0	1	3	0,7	2	5	0	0
70	36	0	1	3	4	1	2	1	1	3	1,4,7	3	3	1	1
71	32	0	1	4	5	0	1	1	1	4	1,6,7	3	4	0	0
72	27	0	0	4	5	0	1	1	1	2	0,2	3	4	1	1
73	33	0	0	4	5	0	1	1	1	1	1,3	2	4	0	0
74	23	0	0	5	0	0	1	1	1	1	1,7	2	4	0	0
75	24	0	1	4	4	0	1	1	1	1	0,7	2	3	0	0
76	32	0	1	3	4	2	1	0	1	2	1,7	2	3	1	1

S.No	Family history of substance use	Family history of any other mental illness	Total DAS score	DAS- Performance evaluation	DAS- Need for approval	DAS- Autonomous attitude	DAS- Perfectionism	Grade of dysfunction on DAS	Brief -COPE total score	Problem focussed total
38	1	0	92	50	18	13	11	1	51	17
39	1	1	102	42	21	30	9	1	62	17
40	0	1	160	68	42	37	13	3	62	18
41	1	1	190	98	40	41	11	4	63	16
42	1	1	147	71	38	29	9	3	51	15
43	0	1	106	49	31	15	11	1	54	19
44	0	1	158	75	38	35	10	3	62	18
45	1	1	122	58	34	22	8	2	66	19
46	0	1	163	92	39	19	13	3	52	15
47	0	1	160	68	42	37	13	3	62	18
48	1	1	190	98	40	41	11	4	63	16
49	0	1	141	61	37	29	14	3	63	20
50	0	1	125	53	34	28	10	2	55	16
51	1	1	96	38	23	27	8	1	57	20
52	1	1	147	71	38	29	9	3	51	15
53	0	1	106	49	31	15	11	1	54	19
54	1	0	178	104	38	22	14	4	58	18
55	1	1	147	71	38	29	9	3	51	15
56	0	1	106	49	31	15	11	1	54	19
57	1	1	147	71	38	29	9	3	51	15
58	0	1	107	49	32	15	11	1	54	19
59	1	1	98	40	23	27	8	1	57	20
60	1	1	166	80	43	31	12	4	59	18
61	0	1	86	46	18	11	11	1	52	16
62	0	1	98	49	23	15	11	1	54	18
63	1	1	98	40	23	27	8	1	57	20
64	1	1	167	82	42	31	12	4	59	18
65	0	1	160	68	42	37	13	3	62	18
66	1	1	188	97	39	41	11	4	63	16
67	0	1	158	75	38	35	10	3	62	18
68	0	1	99	50	23	15	11	1	54	18
69	1	0	92	50	18	13	11	1	51	17
70	1	1	180	95	34	37	10	4	56	16
71	0	1	156	82	43	18	13	3	56	20
72	1	1	158	75	38	35	10	3	62	18
73	0	1	185	96	38	41	10	4	63	16
74	1	1	147	71	38	29	9	3	51	15
75	0	1	106	49	31	15	11	1	54	19
76	1	0	178	104	38	22	14	4	58	18

S.No	Active coping	Use of informational support	Positive reframing	Planning	Emotion focussed total	Emotional Support	Venting	Humour	Acceptance	Self-blame	Religion	Avoidant total	Self-distraction	Substance Use	Denial	Behavioural disengagement
38	5	3	4	5	20	3	3	2	5	4	3	14	6	2	4	2
39	4	2	6	5	24	4	4	4	5	5	2	21	7	6	5	3
40	4	4	4	6	22	3	2	3	6	5	3	22	7	6	4	5
41	3	3	5	5	25	4	3	3	4	7	4	22	5	6	5	6
42	4	3	4	4	20	4	4	2	3	5	2	16	5	4	2	5
43	5	5	3	6	21	5	4	3	3	3	3	14	4	5	2	3
44	3	6	5	4	22	3	3	2	4	7	3	22	7	5	4	6
45	6	4	4	5	27	4	4	4	6	7	2	20	6	5	4	5
46	3	4	4	4	22	4	3	3	4	6	2	15	4	3	3	5
47	4	4	4	6	22	3	2	3	6	5	3	22	7	6	4	5
48	3	3	5	5	25	4	3	3	4	7	4	22	5	6	5	6
49	5	5	4	6	24	5	2	3	5	7	2	19	5	5	4	5
50	5	3	4	4	22	3	3	2	5	6	3	17	4	6	3	4
51	6	4	5	5	23	3	4	2	6	4	4	14	4	6	2	2
52	4	3	4	4	20	4	4	2	3	5	2	16	5	4	2	5
53	5	5	3	6	21	5	4	3	3	3	3	14	4	5	2	3
54	4	4	5	5	23	3	4	3	5	5	3	17	4	4	3	6
55	4	3	4	4	20	4	4	2	3	5	2	16	5	4	2	5
56	5	5	3	6	21	5	4	3	3	3	3	14	4	5	2	3
57	4	3	4	4	20	4	4	2	3	5	2	16	5	4	2	5
58	5	5	3	6	21	5	4	3	3	3	3	14	4	5	2	3
59	6	4	5	5	23	3	4	2	6	4	4	14	4	6	2	2
60	5	4	4	5	23	4	3	3	5	5	3	18	5	5	3	5
61	4	3	4	5	20	4	3	3	5	3	2	14	5	4	3	2
62	5	3	4	5	20	4	3	3	5	3	2	16	5	4	3	2
63	6	4	5	5	23	3	4	2	6	4	4	14	4	6	2	2
64	5	4	4	5	23	4	3	3	5	5	3	18	5	5	3	5
65	4	4	4	6	22	3	2	3	6	5	3	22	7	6	4	5
66	3	3	5	5	25	4	3	3	4	7	4	22	5	6	5	6
67	3	6	5	4	22	3	3	2	4	7	3	22	7	5	4	6
68	5	3	4	5	20	4	3	3	5	3	2	16	5	4	3	2
69	5	3	4	5	20	3	3	2	5	4	3	14	6	2	4	2
70	4	3	4	5	23	4	3	3	4	7	2	17	5	6	2	4
71	5	6	3	6	21	3	2	3	4	4	5	15	6	3	3	3
72	3	3	5	5	25	4	3	3	4	7	4	22	5	6	5	6
73	4	6	5	4	22	3	3	2	4	7	3	22	7	5	4	6
74	4	3	4	4	20	4	4	2	3	5	2	16	5	4	2	5
75	5	5	3	6	21	5	4	3	3	3	3	14	4	5	2	3
76	4	4	5	5	23	3	4	3	5	5	3	17	4	4	3	6

S.No	Age	Gender	Marital status	Education	Occupation	Children	Type of family	Residence	Socio-economic status	Age at which first consumed substance	Type of Substance consumed	Number of substances consumed	Insight Grade	Number of deaddiction therapies taken	Compliance
77	26	0	0	5	0	0	1	1	1	1	1,4,7	2	4	0	0
78	25	0	1	4	4	0	1	1	1	1	0,7	2	3	0	0
79	33	0	1	3	4	2	1	0	1	2	1,7	2	3	1	1
80	38	0	1	4	4	2	2	0	1	1	1,7	2	3	1	1
81	28	0	0	5	5	0	1	1	2	1	1,2	2	4	1	1
82	36	0	1	4	4	1	1	1	2	4	1,7	3	5	1	1
83	24	0	1	4	4	1	1	1	2	4	2,7	3	5	1	1
84	35	0	0	4	5	0	1	1	1	2	3,7	3	3	1	1
85	26	0	0	4	5	0	1	1	1	2	0,2	3	4	1	1
86	24	0	0	4	0	0	2	1	1	1	3,7	2	4	0	0
87	25	0	0	5	0	0	1	1	1	1	1,7	2	4	0	0
88	26	0	0	5	5	0	1	1	2	1	1,2	2	4	1	1
89	34	0	1	4	4	1	1	1	2	4	1,7	3	5	1	1
90	33	0	1	4	4	1	1	1	2	4	2,7	3	5	1	1
91	27	0	0	4	0	0	2	1	1	1	3,7	2	4	0	0
92	35	0	0	4	4	0	1	1	1	2	1,7	2	4	0	0
93	28	0	1	3	5	0	1	1	1	1	0,7	2	3	0	0
94	31	0	0	4	5	0	1	1	1	1	1,7	2	4	0	0
95	34	0	1	4	4	1	1	1	2	4	3,7	3	5	1	1
96	26	0	0	2	0	0	2	0	1	3	0,7	2	5	0	0
97	27	0	0	4	0	0	2	1	1	1	3,7	2	4	0	0
98	25	0	1	4	5	1	1	1	1	2	1,2,7	3	3	0	0
99	33	0	0	4	5	0	1	1	1	2	3,7	3	3	1	1
100	26	0	1	4	5	1	1	1	1	2	1,2,7	3	3	0	0

S.No	Family history of substance use	Family history of any other mental illness	Total DAS score	DAS- Performance evaluation	DAS- Need for approval	DAS- Autonomous attitude	DAS- Perfectionism	Grade of dysfunction on DAS	Brief -COPE total score	Problem focussed total
77	1	1	147	68	39	29	11	3	51	15
78	0	1	106	49	31	15	11	1	54	19
79	1	0	178	104	38	22	14	4	58	18
80	0	1	144	64	37	29	14	3	63	20
81	0	1	125	53	34	28	10	2	55	16
82	0	1	86	46	18	11	11	1	52	16
83	0	1	98	49	23	15	11	1	54	18
84	0	1	160	68	42	37	13	3	62	18
85	1	1	188	97	39	41	11	4	63	16
86	1	1	100	41	24	27	8	1	57	20
87	1	1	147	71	38	29	9	3	51	15
88	0	1	125	53	34	28	10	2	55	16
89	0	1	86	46	18	11	11	1	52	16
90	0	1	100	50	24	15	11	1	54	18
91	1	1	96	39	23	26	8	1	57	20
92	0	1	126	62	38	14	12	2	57	17
93	1	1	100	40	21	30	9	1	62	17
94	0	1	153	70	38	35	10	3	62	18
95	0	1	102	50	26	15	11	1	54	18
96	1	0	95	50	20	14	11	1	51	17
97	1	1	102	42	25	27	8	1	57	20
98	1	1	167	82	42	31	12	4	59	18
99	0	1	160	68	42	37	13	3	62	18
100	1	1	163	80	40	31	12	4	59	18

S.No	Active coping	Use of informational support	Positive reframing	Planning	Emotion focussed total	Emotional Support	Venting	Humour	Acceptance	Self-blame	Religion	Avoidant total	Self-distraction	Substance Use	Denial	Behavioural disengagement
77	4	3	4	4	20	4	4	2	3	5	2	16	5	4	2	5
78	5	5	3	6	21	5	4	3	3	3	3	14	4	5	2	3
79	4	4	5	5	23	3	4	3	5	5	3	17	4	4	3	6
80	5	5	4	6	24	5	2	3	5	7	2	19	5	5	4	5
81	5	3	4	4	22	3	3	2	5	6	3	17	4	6	3	4
82	4	3	4	5	20	4	3	3	5	3	2	14	5	4	3	2
83	5	3	4	5	20	4	3	3	5	3	2	16	5	4	3	2
84	4	4	4	6	22	3	2	3	6	5	3	22	7	6	4	5
85	3	3	5	5	25	4	3	3	4	7	4	22	5	6	5	6
86	6	4	5	5	23	3	4	2	6	4	4	14	4	6	2	2
87	4	3	4	4	20	4	4	2	3	5	2	16	5	4	2	5
88	5	3	4	4	22	3	3	2	5	6	3	17	4	6	3	4
89	4	3	4	5	20	4	3	3	5	3	2	14	5	4	3	2
90	5	3	4	5	20	4	3	3	5	3	2	16	5	4	3	2
91	6	4	5	5	23	3	4	2	6	4	4	14	4	6	2	2
92	3	3	5	6	22	3	3	2	6	6	2	18	6	4	4	4
93	4	2	6	5	24	4	4	4	5	5	2	21	7	6	5	3
94	3	6	5	4	22	3	3	2	4	7	3	22	7	5	4	6
95	5	3	4	5	20	4	3	3	5	3	2	16	5	4	3	2
96	5	3	4	5	20	3	3	2	5	4	3	14	6	2	4	2
97	6	4	5	5	23	3	4	2	6	4	4	14	4	6	2	2
98	5	4	4	5	23	4	3	3	5	5	3	18	5	5	3	5
99	4	4	4	6	22	3	2	3	6	5	3	22	7	6	4	5
100	5	4	4	5	23	4	3	3	5	5	3	18	5	5	3	5

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The Principal,
DMC, Ludhiana.

Subject: **Approval of Plan of Thesis.**

This is to inform you that the Faculty of Medical Sciences in its meeting held on 29.10.2021 has approved the plan of thesis of **Ardaas Preet Singh Sandhu**, a student of your college for **MD Psychiatry** along with the names of Supervisor/Co-Supervisor as under:-

Topic Plan of Thesis
Dysfunctional attitudes and coping mechanism among substance dependent patients.

Supervisor
Dr. Navkiran Sooch Mahajan
Prof.,
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The student has to submit the four copies of thesis (along with PDF format) , to the Controller of Examinations, BFUHS, Faridkot, at least six months before the commencement of theory examination, if he/she is otherwise eligible to take the examination. He /She must directed to attach a photocopy of this letter with the forwarding letter while submitting thesis to the University along with the letter of approval of University for change of supervisor/Co-Supervisor, change of topic,(if any).

S P Singh

Dr. S P Singh MS(Oph)
Controller of Examinations

Note :

105. If any discrepancy found regarding topic of thesis or Supervisor/Co-Supervisor, inform undersigned within one month after issue of this letter.

106. The student may submit the thesis as per the schedule already conveyed i.e for May/June examination 30th Nov of the preceding the year of examination and for Nov/Dec examinations 31st May of the year of examination.

4/58-2022

DYSFUNCTIONAL ATTITUDE AND COPING MECHANISM AMONG SUB-STANCE DEPENDENT PATIENTS

THESIS PROPOSAL

FOR APPROVAL OF SUBJECT OF THESIS TO BE SUBMITTED

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF

DOCTOR OF MEDICINE

In

PSYCHIATRY

OF THE

BABA FARID UNIVERSITY OF HEALTH SCIENCES
FARIDKOT

MARCH, 2021

DR. ARDAASPREET SINGH SANDHU

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ABSTRACT OF PLAN OF THESIS

Title	DYSFUNCTIONAL ATTITUDES AND COPING MECHANISM AMONG SUBSTANCE DEPENDENT PATIENTS
For the degree of	MD PSYCHIATRY
Name of the candidate	DR. ARDAASPREET SINGH SANDHU
Supervisor	DR. NAVKIRAN SOOCH MAHAJAN, PROFESSOR, DEPARTMENT OF PSYCHIATRY
Co-supervisor	DR.RANJIVE MAHAJAN , PROFESSOR AND HEAD DEPARTMENT OF PSYCHIATRY
Institution	Dayanand Medical College & Hospital, Ludhiana
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Introduction: Substance abuse is a complex condition, manifested by compulsive substance use despite harmful consequence. People with addiction have an intense craving, develop tolerance for these substances and have withdrawal symptoms in the absence of it. This population of substance dependent people exhibit dysfunctional attitudes and maladaptation coping mechanisms.

Aim of Study: Assess the dysfunctional beliefs in the substance abusers and the coping mechanisms among them.

Materials & methods: This is a cross sectional study to be conducted on 100 substance dependent patients presenting to psychiatry department of D.M.C.H Ludhiana (Punjab). Dysfunctional attitudes were assessed using the Dysfunctional Attitude Scale (D.A.S) and coping method assessed using the Brief Cope Scale

Clinical Significance: The present study will assess the dysfunctional attitudes and the subsequent coping mechanism in substance dependent patients which will help us in better understanding the psychological aspects of people with substance dependence. The study will further guide as a key for psychological intervention along with pharmacological intervention targeting these dysfunctional attitudes and may overall help in relapse prevention and better outcome of rehabilitation as well as better quality of life of patients.

Keywords: Substance abuser, Dysfunctional attitude, Coping.

(Signature)	(Signature)	(Signature)	(Signature)
Candidate	Co-supervisor	Supervisor	Principal

CERTIFICATE OF FACILITIES AVAILABLE

This is to certify that the facilities for work on the subject of thesis titled **"DYS-FUNCTIONAL ATTITUDES AND COPING MECHANISM AMONG SUB-STANCE DEPENDENT PATIENTS"** exist in the Department of Psychiatry, DMC&H, Ludhiana and will be provided to the candidate. We will see that the data being included in the thesis is genuine and is collected by the candidate herself under our supervision and guidance.

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Approved: Yes / No

Dr. Sandeep Puri
Chairperson
Research Committee

Approved: Yes / ~~No~~

Prof. Arvind Malhotra
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3	COURSE OF STUDY AND SUBJECT	MD PSYCHIATRY
4	DATE OF ADMISSION OF COURSE	27/07/2020
5	TITLE OF THE TOPIC	DYSFUNCTIONAL ATTITUDES AND COPING MECHANISM IN SUBSTANCE DEPENDENT PATIENTS.

6. BRIEF RESUME OF THE INTENDED WORK

6.1 NEED FOR THE STUDY

Substance dependence is a chronic and highly prevalent condition leading to dysfunction in personal, occupational and social area that can occur during periods of heavy alcohol consumption and even following treatment. Substance abuse is a complex condition, manifested by compulsive substance use despite harmful consequence.[1] According to WHO estimates in year 2010, 3.4-6.6 per cent of the world's population had used an illicit substance at least once in their life. This population of substance dependent people exhibit dysfunctional attitudes and maladaptation coping mechanisms. According to the National Survey on Drug Use and Health (NSDUH), 19.7 million American adults (aged 12 and older) battled a substance use disorder in 2017.[2] Recent report of WHO (2014) suggests that 38.3% of the global population consume some substance.[3] India whose population is just over a billion, 62.5 million people use alcohol, 8.75 million use cannabis, two million use opiates, and 0.6 million use sedatives or hypnotics, 17- 26% of these people can be classified as dependent users who need urgent treatment in a study done by Sanjay Kumar.[4] The prevalence of substance abuse among study group was 65.5% and most common substance abused was alcohol (41.8%), followed by tobacco (21.3%). A high prevalence of heroin abusers was noted among study subjects (20.8%). The prevalence of nonalcohol and non-tobacco substance abuse was 34.8%.[5] Thus drug dependence has become a worldwide crisis as it is associated with adverse social and economic consequences as well as physical and mental illness,. Addiction may lead to disrupting the individual's physical and mental health, family, social, ethical and work harmony. Drug addiction has a structure that may have negative outcomes such as breakdowns in relationships with parents and the social lives of the people involved.[6] Many negative factors, such as rapid increase of the population; late marriage and child births, lack of education, weakening of cultural and social norms;

and open and free use of the Internet and media, have increased the prevalence of substance abuse among the youth.

Stress and dysfunctional thoughts are important determinants that lead individuals to start using substances or make them more addicted to drugs, stimulating worsening substance-abuse issues. it has been reported that participants are in their 20s when they started drinking regularly. A wide range of psychological, social, domestic, and biological factors are involved in the etiology of substance abuse, none of which can be a determinant factor on its own. Among the psychological factors contributing to the onset of substance abuse are dysfunctional attitudes. Dysfunctional attitudes are beliefs and attitudes that induce negative thoughts about the self, others, and the future.[7]

Dysfunctional attitudes are biased assumptions and beliefs that the subject has toward himself and his surrounding and future world. In other words, dysfunctional attitudes (DA) are attitudes and beliefs that predispose the individual toward depression or psychological disorders, as a whole.[8-9] Coping mechanisms are compulsions, or habits formed over time, that serve to help a person manage with particular situations or stress levels. Not all coping mechanisms are maladaptive or destructive; however, addiction is both.[10] Lazarus and Folkman identified three types of coping methods, namely, problem focused, emotion focused, and avoidance. Several studies have suggested that substance-use behavior is associated with coping methods that are not directed toward adaptation.[11-12] A negative relationship was found between dysfunctional coping type subscale and substance abuse of the patients depending on their age at which they first started using these drugs. Dysfunctional attitudes are reportedly associated with maladaptive coping strategies. There is a relationship between dysfunctional thinking patterns and coping attitudes such as avoidance and an inability to solve problems. Dysfunctional attitudes are related to every aspect of ones life who is under addiction. Religion/culture is one example of an emotional coping strategy, for instance in Sikhism the use of any tobacco product or smoke via drug use from a sardars nose/mouth are thought to be very inappropriate due to social and religious stigma

compared to other religions so they tend to consume more alcohol. Dysfunctional beliefs cause substance use, but also increased number of reasons to use.

Coping with these dysfunctional attitudes needs to be known and documented for further research to make de addiction and society more comfortable in treating addicts with a proper understanding. With the advancing world people tend to either get depressed or start some substance use to cope up with the pressure. The use of effective coping skills can often help improve mental and emotional well-being. People who are able to adjust to stressful or traumatic situations (and the lasting impact these incidents may have) through productive coping mechanisms may be less likely to experience anxiety, depression, and other mental health concerns as a result of painful or challenging events.

People who find themselves defaulting to maladaptive coping mechanisms and/or experience difficulty utilizing effective coping strategies may eventually see a negative impact on mental and emotional well-being. Those who have a difficult time knowing how to cope with anxiety, stress, or anger may fall into the habit of relying on a maladaptive coping mechanism.[13-14] Adaptive stress coping leads to improvement and better adaptation, according to stress-coping research.

With the difference in the beliefs, attitudes, coping from area to area or culture to culture there is a need to study about these in Punjab as it needs more study in this aspect with respect to the drug menace rising from the last 10-12 years. There is dearth of Indian literature in this context of Dysfunctional belief and coping mechanism among substance abusers. Soo a study done in Punjab can help treating the people in a better way and can cover many aspects of the mental status of the substance abusers. To sum up, substance dependence is a highly prevalent mental health issue in society which is linked to dysfunctional attitudes and maladaptive coping in such people. Assessing these dysfunctional attitudes and maladaptive coping methods will help in inclusion of adequate psychological intervention to the pharmacological

management of such patients in terms of recovery, relapse prevention and rehabilitation. Hence, the present study has been planned.

6.2 REVIEW OF LITERATURE

Substance use problems are among the major contributors to the global disease burden, which includes disability and mortality. The benefits of treatment far outweigh the economic costs. Despite the availability of treatment services, however, the vast majority of people with substance use disorders do not seek or use treatment but insteas develop some dysfunctional attiture and a maladaptive coping mechanism to deal with the dependenc. Soo a study is needs to get all cards at one place to plan some further plan of action.

A study was conducted between on 51 patients admitted to the Alcohol and Drug Addiction Treatment Center (ADATC) of a state hospital. The average COPE score of the drug-addicted patients was found to be 171.60 ± 23.35. The average DAS score of the drug-addicted patients was determined to be 161.66 ± 36.94. A statistically significant difference was found between the DAS and COPE scores of the patients ($P < 0.05$).[15]

Another study by M Tabatabaeichehr et al, to investigate the effectiveness cognitive–behavioral therapy on improving irrational beliefs in male substance abusers. In a semi-experimental study, by MMT (Methadone maintenance therapy) therapy of bojnurd, in an experimental and a control groups., cognitive-behavioral approach while control group only receive routine treatment of MMT center. Jones irrational beliefs questionnaire form was used. Irrational beliefs scores of both groups before the intervention were not significant, but showed significant level of difference after the intervention. The overall mean pre-intervention score and post-intervention score of experimental group showed a meaningful decrease.[16]

A causal-comparative study was conducted Robat-Karim's addiction rehabilitation centers et al. The population under study consisted of A100 ordinary individuals 100 substance abusers were selected through simple random sampling. The two groups differed significantly in their dysfunctional attitudes and problem-focused and emotion-focused coping strategies. Substance-dependent individuals applied emotion-focused coping more and had greater dysfunctional attitudes

than the healthy ones, and the latter applied problem-focused strategies more.[17]

This study by Susan E Ramsey et al, the validity of the distinction between substance-induced and independent major depressive disorder (MDD) among alcoholics utilizing variables in 166 alcohol-dependent patients with elevated depressive symptoms also compared both of these groups to participants who have never met criteria for a depressive episode (NMDE). Results suggest depressed alcoholics who have experienced episodes of depression independent of excessive substance use possess cognitive vulnerabilities and coping deficits that may render them prone to depression.[18]

This research carried out by Kobra Haj Alizadeh et al, in the city of Bandar Abbas, and to compare the with the control group. This was a study in 100 substance abusers were compared with 100 of control group who were selected using convenience sampling and were also demographically matched. Data were gathered using a demographic questionnaire, clinical interview, dysfunctional attitudes scale (DAS), Depression Anxiety Stress Scale (DASS). The results were that dysfunctional attitudes could be as a Vulnerability Factor that increase abuse of substance consequently use of cognitive therapy could be helpful and effective in prevention and treatment of the addicts.[19]

A cross-sectional study conducted by Zahra Karimi, Leila Haghshenason et al, 60 addicted people and 60 non-addicted people. The Adult Attachment Scale of Hazan and Shaver, Allport Religious Orientation Scale, and the 26-item Dysfunctional Attitude Scale were used to measure the variables. The results of this study SHOW importance of safe and ambivalent attachment styles and dysfunctional attitudes. Thus, attending to these factors in studies and interventions related to the treatment of substance abuse disorders is essential.[20]

Study by Kaur et al, the difference between dysfunctional attitudes and coping strategies in addicts and non-addicts to addicts. A sample of Sixty (N=60) participants, from which thirty were addicts (N=30) and thirty were non-addicts (N=30) taken. To measure the dysfunctional

attitudes and Coping Strategies; the Dysfunctional Attitude Scale (DAS-24) and Ways of Coping Questionnaire (WCQ) The data were subjected to correlation, regression and't analysis and the major finding of the study reveals that there is the difference between the dysfunctional attitudes and coping strategies in addicts and non-addicts and addicts hold higher dysfunctional attitudes as compared to non-addicts.[21]

A series of population-based and epidemiological studies Ann N Y Acad et al have identified specific stressors and individual-level variables that are predictive of substance use and abuse. A review of evidence indicated the effects of drug use and abuse on stress responses and dopamine transmission is presented, along with altered emotional and motivational responses associated with craving and relapse to drug use. {22]

The study by Ebrahim Shafiei, et alexamines relapse coping strategies in young addicts in Substance Abuse Treatment Centers in Iran. Based on the findings, addicts desire to reuse substance in a hypothetical high risk situation and it was hard to handle this situation. They used coping skills to avoid this situation at an average level. Improving self-efficacy skills through teaching coping skills can help them in this way.[23]

Factor Analysis of Coping Strategies among Subjects of Alcohol Dependence Syndrome: A Study at Tertiary Care Center by Rohit v et al The total variance explained by the factors was only around 48%, personality traits related to coping and pharmacological treatments were not controlled.[24]

6.3 AIMS AND OBJECTIVES OF THE STUDY

1. To study the dysfunctional attitudes of substance dependent patients.
2. To study the coping mechanism used by substance dependent patients.

7. MATERIALS AND METHODS

7.1 Source of Data

Study will be conducted on 100 patients of substance dependence according to ICD10 CRITERIA presenting to both inpatient and outpatient in department Of Psychiatry, D.M.C & H Ludhiana (Punjab)

7.2 METHOD OF COLLECTION OF DATA

SAMPLE COLLECTION- Study will be conducted on 100 patients between 18-65years diagnosed as substance users for atleast 1 year to study the dysfunctional attitudes and coping mechanism presenting to DMC&H, Ludhiana, PUNJAB.

INCLUSION CRITERIA:

1) Patients who are between 18 to 65 years of age.
2) Diagnosed cases of substance use as per ICD10.
3) Either male or female patients.
4) Patients who have given consent for the study.

EXCLUSION CRITERIA:

1. Patients below 18 years of age and above 65 years of age.
2. SUBSTANCE DEPENDENT PATIENTS with intoxication, delirium, dementia, amnestic syndrome.
3. SUBSTANCE DEPENDENT PATIENTS of with other psychiatric co morbidities such as depression, anxiety, psychosis, mania, mixed mania and depression or medical comorbidities. like chronic liver disease, H.I.V, C.O.P.D, seizures.
4. Patients consuming other pharmaceutical substances such as pregabalins, codeine, gabapentin etc.
5. Patients with behavioural addiction.'
6. Pregnant females with any substance use

METHADOLOGY:

The data from all consenting patients will be enterd in structured proforma as follows.

1. Sociodemographic Proforma- This shall include name of patient, age, gender, marital status, number of children, occupation, education, address, contact number, the various substances used, duration of substance use, past history of any deaddiction treatment, history of any medical comorbidities like hypertension, Diabetes mellitus, Score on DAS scale.
2. Dysfunctional Attitude Scale- The DAS has been developed by Weissman and Beck. in order to measure the beliefs and attitudes underlying different forms of psychopathology according to the Beck's cognitive theory. The score of the 40 questionarre in 7 sub categories range is 40–280, and a high score indicates that the patient often exhibits dysfunctional attitudes.

3. The Brief-COPE is a 28 item self-report questionnaire designed to measure effective and ineffective ways to cope with a stressful life event. “Coping” is defined broadly as an effort used to minimize distress associated with negative life experiences. Avoidant Coping, which is characterised by the subscales of denial, substance use, venting, behavioural disengagement, self distraction and self-blame. Approach Coping is characterized by the subscales of active coping, positive reframing, planning, acceptance, seeking emotional support, and seeking informational support.

OUTCOME

The study on Dsyfunctional attitudes and coping mechanism in substance dependent patients is to study the various ways by with the substance dependent individuals develop dysfunctional attitude towards the substance dependence in

daily life and how they cope up with the issue in state of Punjab.

STATISTICAL ANALYSIS-

Data will be described in terms of range; mean ±standard deviation (± SD), median, frequencies (number of cases) and relative frequencies (percentages) as appropriate. All statistical calculations will be done using (Statistical Package for the Social Science) SPSS 21version (SPSS Inc., Chicago, IL, USA) statistical program

7.3 DOES THE STUDY REQUIRE ANY INVESTIGATIONS OR INTERVENTIONS TO BE CONDUCTED ON PATIENTS OR OTHER HUMANS OR ANIMALS? IF SO, PLEASE DESCRIBE BRIEFLY.

No

7.4 HAS ETHICAL CLEARANCE BEEN OBTAINED FROM YOUR INSTITUTION IN CASE OF 7.3?

Attached herewith

LIST OF REFERENCES

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PATIENT PROFILE

GENERAL

Appearance-

Sensorium-

Blood Pressure-

Respiratory Rate-

Heart Rate-

Saturation-

SYSTEMIC

C.V.S

RESPIRATORY SYSTEM-

PER ABDOMEN-

Signature of Candidate **Signature of Supervisor**

CNS-

NEUROLOGICAL-

OTHERS(if any) -

I.V drug marks-

Abcess-

Preuritis-

Signature of Candidate **Signature of Supervisor**

SOCIODEMOGRAPHIC PROFILE

MRD No-.

DATE--

NAME- AGE - GENDER-

MRD NO-

MARITAL STATUS-

EDUCATION-

OCCUPATION

LOSS OF FUNCTION -

INCOME-

CHILDEN-

TYPE OF FAMILY- JOINT/NUCLEAR/LIVING ALONE-

ADDRESS -

CONTACT NO-

AGE AT WHICH 1ST CONSUMED SUBSTANCE-

NO. AND TYPES OF SUBSTANCE CONSUMED-

DURATION OF SUBSTANCE USE /COURSE OF SUBSTANCE USE-

INSIGHT GRADE -

NUMBER OF DEADDICTIONS THERIPIES-

SIGNATURE OF CANDIDATE **SIGNATURE OF SUPERVISOR**

COMPLIANCE-

FAMILY HISTORY Of SUBSTANCE USE/DEPENDENCE-

FAMILY HISTORY Of ANY MENTAL ILLNESS EXCEPT -SUBSTANCE DEPENDENCE-

GENERAL PSYCHOPATHOLOGICAL SCORE

DATE SCORE

1. DAS SCORE
2. BRIEF COPE SCORE

SIGNATURE OF CANDIDATE **SIGNATURE OF SUPERVISOR**

INFORMED PATIENT CONSENT

Date: _____

I.....D/o, W/o, S/o..... .....am willing to participate in the study **"DYSFUNCTIONAL ATTITUDES AND COPING MECHANISM AMONG SUBSTANCE DEPENDENT PATIENTS"** The procedure with its complications has been explained to me in local vernacular language. I have fully understood that no special tests and extra expenditure in any form, merely for the purpose of thesis is being carried out. I am free to opt out the study any time without assigning any reason.

.....
Signature of the Witness

.....
Signature of the patient

Name:

Signature of Candidate

Signature of Supervisor

मरीज अनुमति फार्म

तिथि _____

मैं _____ पत्नी/पुत्र/पुत्री _____

निवासी _____

इस शोधकार्य "**DYSFUNCTIONAL ATTITUDES AND COPING MECHANISM AMONG SUBSTANCE DEPENDENT PATIENTS**" में भाग लेने के लिए सहमत हूँ। मैं इस शोधकार्य में भाग लेने के लिए अपनी स्वेच्छा से तैयार हूँ। मैं पुष्टि करता/करती हूँ की यह स्वीकृति देने के लिए मुझे कोई आर्थिक प्रलोभन नहीं दिया गया और न ही दबाव डाला गया है। मुझे इस शोधकार्य का उद्देश्य स्पष्ट कर दिया गया है और मुझे यह विश्वास है की यह विज्ञान और मानवता के लाभ के लिए है। मुझे इस शोधकार्य में होने वाले जोखिम के बारे में समझा दिया गया है और मेरी समझ में यह जोखिम बहुत मामुली है।

मैं इस शोधकार्य में भाग लेने के सम्बन्ध में किसी भी समय अपनी अस्वीकृति व्यक्त कर सकता/सकती हूँ और मेरे अस्वीकृति व्यक्त करने का मेरे इलाज पर कोई प्रभाव नहीं पड़ेगा।

_____ _____

गवाह के हस्ताक्षर रोगी के हस्ताक्षर/अंगूठे का निशान

नाम: नाम:

_____

अन्वेषक केहस्ताक्षर

_____

विद्यार्थी के हस्ताक्षर

ਮਰੀਜ਼ ਰਜ਼ਾਮੰਦੀ ਫਾਰਮ

ਮਿਤੀ_____

ਮੈ_____ਪਤਨੀ/ਪੁੱਤਰ/ਪੁੱਤਰੀ_____

ਵਾਸੀ _____

"DYSFUNCTIONAL ATTITUDES AND COPING MECHANISM AMONG SUBSTANCE DEPENDENT PATIENTS" ਤੇ ਚਲ ਰਹੀ ਖੋਜ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਰਜ਼ਾਮੰਦ ਹਾਂ। ਇਸ ਖੋਜ ਕੰਮ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਮੈ ਆਪਣੀ ਮਰਜ਼ੀ ਨਾਲ ਤਿਆਰ ਹਾਂ। ਮੈ ਇਹ ਦਸਣਾ ਚਾਹੁੰਦਾ ਹਾਂ/ ਚਾਹੁੰਦੀ ਹਾਂ ਕੇ ਇਹ ਰਜ਼ਾਮੰਦੀ ਦੇਣ ਵਾਸਤੇ ਮੈਨੂ ਕਿਸੇ ਵੀ ਤਰਾਂ ਦਾ ਲੋਭ-ਲਾਲਚ ਨਹੀ ਦਿੱਤਾ ਗਿਆ ਅਤੇ ਨਾ ਹੀ ਕੋਈ ਦਬਾ ਪਾਇਆ ਗਿਆ ਹੈ। ਮੈਨੂ ਇਸ ਖੋਜ ਦਾ ਮਨੋਰਥ ਸਮਝਾ ਦਿੱਤਾ ਗਿਆ ਹੈ ਅਤੇ ਮੈਨੂ ਇਹ ਭਰੋਸਾ ਦਵਾਇਆ ਗਿਆ ਹੈ ਕੇ ਇਹ ਖੋਜ ਵਿਗਿਆਨ ਅਤੇ ਮਾਨਵਤਾ ਦੀ ਭਲਾਈ ਲਈ ਹੈ। ਮੈਨੂ ਇਸ ਖੋਜ ਵਿਚ ਹੋਣ ਵਾਲੇ ਖਤਰੇ ਬਾਰੇ ਸਮਝਾ ਦਿੱਤਾ ਗਿਆਹੈ ਅਤੇ ਮੈਨੂ ਇਹ ਯਕੀਨ ਹੈ ਕੇ ਇਹ ਖਤਰਾ ਬਹੁਤ ਮਾਮੂਲੀ ਹੈ। ਮੈਨੂ ਇਸ ਖੋਜ ਕੰਮ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਦਾ ਢੰਗ–ਤਰੀਕਾ ਸਮਝਾ ਦਿੱਤਾ ਗਿਆ ਹੈ।

ਮੈ ਇਸ ਖੋਜ ਕੰਮ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਬਾਰੇ ਆਪਣੀ ਰਜ਼ਾਮੰਦੀ ਕਿਸੇ ਵੀ ਸਮੇ ਵਾਪਸ ਲੈ ਸਕਦਾ ਹਾਂ/ ਸਕਦੀ ਹਾਂ ਅਤੇ ਮੇਰੀ ਰਜ਼ਾਮੰਦੀ ਵਾਪਸ ਲੈਣ ਦਾ ਮੇਰੇ ਇਲਾਜ ਤੇ ਕੋਈ ਅਸਰ ਨਹੀ ਹੋਵੇਗਾ।

_____ _____

ਗਵਾਹ ਦੇ ਹਸਤਾਖਰ ਮਰੀਜ਼ ਦੇ ਹਸਤਾਖਰ

ਮਿਤੀ_____ ਮਿਤੀ_____

ਪਤਾ _____ ਪਤਾ _____

_____

ਨਿਰੀਖਕ ਦੇ ਹਸਤਾਖਰ

_____

ਸਿਖਿਆਰਥੀ ਦੇ ਹਸਤਾਖਰ